AN EXPLORATION OF THE INTRA- AND INTERPERSONAL PATHWAYS LINKING INTERPERSONAL GOALS TO WEIGHT MANAGEMENT GOAL PURSUIT

by

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ABSTRACT

NICOLE MELISSA HILAIRE. An exploration of the intra- and interpersonal pathways linking interpersonal goals to weight management goal pursuit. (Under the direction of DR. AMY CANEVELLO)

Using Pietromonaco and colleagues' (2013) model as a guiding framework, I designed an empirically testable model that integrates theory and constructs from relationship science, affective science, and health psychology to explore the impact of social relationships on weight management. The present study focused on two interpersonal goals as indicators of relational orientations, which have strong and consistent implications for psychological, physical, and relational well-being (Crocker & Canevello, 2012). These relational orientations were expected to act upon weight management through two paths: an *intrapersonal* pathway connecting interpersonal goals to intentions to persist through emotional processes and an *interpersonal* pathway connecting interpersonal goals to intentions to persist through dyadic processes**.** This model was explored in a cross-sectional study of 71 romantic couples with weight management goals. Regarding the intrapersonal pathway, compassionate and self-image goals were generally unrelated to emotional responses to progress and setbacks. Empowered responses to progress and ashamed responses to setbacks were weakly associated with intentions to persist. Regarding the interpersonal pathway, partners' compassionate goals were associated with greater provision of goal-relevant partner support. Partners' self-image goals were related to less partner support when actors or partners reported a lower BMI. In turn, partner support was conditionally related to actors' intentions to persist. Results offer insight into how compassionate and self-image goals contribute to own and romantic partner's

regulation of weight management goals, providing a nuanced perspective on the highly interdependent context of weight management.

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CHAPTER 1: INTRODUCTION AND REVIEW OF LITERATURE

Despite the many benefits of weight management for health and disease (NIH, 1998), most Americans do not meet current diet and exercise guidelines (WHO, 2018). Weight management is a remarkably difficult goal marked by rare glimpses of short-term success (Brownell & Wadden, 1992; Wadden et al., 1996) and rapid returns to baseline weight (Heatherton et al., 1997). To address the need to improve diet and exercise habits in the U.S., the current study adopts a relational orientation framework using egosystem-ecosystem theory of social motivation (Crocker & Canevello, 2008) to explore the influence of two interpersonal goals—compassionate and self-image goals—on weight management goal pursuit. Compassionate goals involve being supportive and constructive in relationships with others out of concern for their well-being, whereas self-image goals involve constructing, maintaining, and defending a desired image of the self (Crocker & Canevello, 2008). The hypothesized model elucidates two pathways through which compassionate and self-image goals may influence weight management goal persistence. First, the model depicts an *intrapersonal, regulatory* pathway whereby interpersonal goals predict emotional responses to setbacks and progress that, in turn, predict *own* weight management goal persistence. Second, the model depicts an *interpersonal* pathway whereby interpersonal goals predict partner support that, in turn, predicts *partners'* weight management goal persistence.

Significance of Weight Management

Overweight and obesity are increasing in prevalence in the US. Currently, 70.7% of adults (approximately 160 million Americans) and almost 30% of children are overweight or obese (DHHS, 2017; Ng et al., 2014), a trend disproportionally affecting

minorities and older adults. People with excess weight or obesity are at an increased risk of developing a number of serious diseases and conditions, such as type 2 diabetes, heart disease, stroke, and certain cancers (NIH, 1998). The cost of managing obesity-related conditions in the US is also rising—an estimate from 2008 calculated the annual medical cost at $147 billion (Finkelstein, Trogdon, Cohen, & Dietz, 2009). Fortunately, diet and physical activity are two modifiable risk factors shown to prevent the development and progression of obesity-related diseases and conditions (Patnode, Evans, Senger, Redmond, & Lin, 2017).

Weight management interventions commonly target diet and physical activity as the primary lifestyle habits contributing to overweight and obesity. Healthy diets are generally those that are low in dietary fat, saturated fat, sugars, and sodium and high in dietary fiber, fruits, and vegetables (Kumanyika et al., 2000; WHO, 2015). Most Americans do not meet current fruit and vegetable consumption recommendations (DHHS, 2015). Indeed, adults only eat fruit 1.1 times/day and vegetables 1.6 times/day (CDCP, 2013). Physical activity refers to bodily movement that raises one's heartbeat (aerobic activity; e.g., biking, jogging, swimming) and exercise that increases muscle strength (e.g., lifting weights, resistance training). According to WHO guidelines, adults should get approximately 150 minutes of moderate physical activity per week or its equivalence in moderate and vigorous activity (WHO, 2018). Again, only 21% American adults meet recommendations for physical activity (Hallal et al., 2012).

While there is strong evidence for the benefits of healthy eating and physical activity for health, many Americans struggle to change poor lifestyle habits. Dieting attempts rarely create more than short-term success (Brownell & Wadden, 1992; Wadden

et al., 1996), with nearly 95% of those who experience weight loss returning to or surpassing their baseline weight within a few years (Heatherton et al., 1997). Further, interventions focused on improving diet are not always successful (Kumanyika et al., 2000). Despite the many benefits of activity and dietary change for health and disease, initiating and maintaining health behavior change remains remarkably difficult (Montesi et al., 2016; Nielsen et al., 2018). But why? The illusive "intention-behavior gap," inherently an issue of self-regulation, has stimulated much of the current research on health behavior (Sheeran & Webb, 2016). Consequently, there remains a need for research illuminating meaningful predictors and mechanisms of health behavior change for weight management.

Intrapersonal Predictors of Weight Management Goals and Behaviors

Social psychologists have uncovered many of the cognitive processes that influence goal striving (Baumeister, Schmeichel, & Vohs, 2007; Fitzsimons & Finkel, 2010). An individual is more likely to achieve a goal, such as weight loss, when they forgo immediate needs or wants in pursuit of long-term rewards (i.e., delay of gratification; Dassen, Houben, Allom, & Jansen, 2018) and when they have confidence in their ability to lose weight (i.e., self-efficacy; Linde, Rothman, Baldwin, & Jeffery, 2006). They are also more likely to succeed when they dedicate their limited self-control resources toward their weight loss goal versus other, peripheral goals (i.e., self-regulatory strength; Vohs & Heatherton, 2000) and when they appraise setbacks as opportunities to learn instead of signs of inadequacy (i.e., self-theories; Dweck, 2013). These psychological processes have been examined in a wide range of health behavior goal

contexts and appear in a number of health behavior theories (de Ridder & de Wit, 2006; Diefenbach et al., 2008).

While much is known about the cognitive processes that facilitate goal attainment, less attention has been paid to the role of affective processes. Most theories of self-regulation highlight the central role of emotion in directing and monitoring goal-related progress (de Ridder & de Wit, 2006; Mann et al., 2013). Emotional responses are thought to be integrally linked with cognitive processes (Cameron & Leventhal, 2003), including perception, attention, learning, memory, and decision-making (see Dolan, 2002 for review). Further, emotional responses are considered crucial elements of the motivational system, as reactions to appraisals of progress, as targets of regulated, and as predictors of cognitions and behaviors (Cameron & Leventhal, 2003). This view aligns with broader social psychological approaches theorizing affect to hold important informational properties (Schwartz & Clore, 1996). Other domains echo the varied functions of affect, suggesting that affect serves as *information* or a signal of importance, a *spotlight* on new or relevant information, a *motivator* of processing and behavior, and a *common currency* across experiences to facilitate judgements and decisions (Peters, Lipkus, & Diefenbach, 2006).

The goal striving literature has focused primarily on the informational and motivational roles of goal-relevant emotions. Carver and Scheier (1998) posit that affect arises as part of a feedback system during goal pursuit. In this system, positive emotions arise to signal faster than needed (or expected) goal progress, whereas negative emotions arise to signal slower than needed (or expected) goal progress. Because affect is posited to reflect an error signal in a feedback loop, experiencing positive or negative affect

signals a need to adjust behavior to maintain equilibrium. People should, therefore, respond to positive affect by reducing effort (or coasting) and respond to negative affect by increasing effort (or pushing; Carver, 2004).

A second perspective, based on the hedonic principle, suggests that positive emotions should increase and negative emotions should decrease goal pursuit efforts (Ilies & Judge, 2005). Experiencing positive emotions during goal pursuit should promote greater investment in the goal in an attempt to increase the frequency of pleasant feelings associated with goal success. Negative emotions should lead to disengagement and redirection of effort toward other valued goals in an attempt to minimize experiencing unpleasant feelings of goal failure. Failure to progress at a goal may produce negative affect accompanied by an impulse to withdraw or disengage that may involve scaling back the goal (de Ridder & de Wit, 2006) or reprioritization of an alternative goal (Wrosch, Scheier, Miller, Schulz, & Carver, 2003).

Research conducted outside of the emotion literature typically examines emotion in terms of broad affective dimensions (i.e., positive vs. negative affect). Although affective processes are linked to a number of important health outcomes (e.g., Cohen & Pressman, 2006) and goal-directed behavior (Louro, Pieters, & Zeelenberg, 2007; Nelissen, de Vet, & Zeelenberg, 2011), discrete emotions are rarely assessed or incorporated into theoretical models (Tracy & Robins, 2004). Examination of specific, discrete emotions affords researchers the opportunity for increased precision and predictive power, particularly for health behaviors and outcomes (Consedine & Moskowitz, 2007). Yet, only a few studies have examined the consequences of discrete

positive and negative emotions for goal pursuit (e.g., Emmons & Mishra, 2011; Williams & DeSteno, 2008).

Metcalfe and Mischel (1999) offer another perspective that may contribute to our understanding of how discrete emotions influence goal pursuit. Their theory suggests that self-regulation and self-control involve two systems: a cold, cognitive system that is complex, reflective, and slow, and a hot, emotional system that is simple, reflexive, and fast. The cold system is theorized to bolster goal pursuit by allowing people to keep goals active in their mind and by monitoring progress. The hot system, on the other hand, is theorized to thwart goal pursuit because experiences of intense, self-conscious emotions make it difficult to keep long-term goals in mind. When people are in the hot system, goals should make them feel *afraid* and *confused*, progress should make them feel intense highs (e.g., joy, pride, relief), and setbacks should make them feel intense lows (e.g., shame, guilt, embarrassment; Crocker, Moeller, & Burson, 2010). Such high intensity emotions should have negative consequences for intentions to persist.

Crocker and colleagues (2010) build on Metcalfe and Mischel's (1999) theory by offering a third, intermediate system called the "warm" system. Like the hot system, the warm system is theorized to be emotional in nature. However, unlike the hot system, the emotions generated in this system are other-directed versus self-directed. As in the cool system, the warm system should allow people to maintain focus on long-term goals and monitor progress. When people are in the warm system, goals should make them feel *clear* and *connected,* progress should make them feel *humble, compassionate,* and *grateful*, and setbacks should make them feel *human, authentic,* and *realistic*. Thus,

experiences of low intensity emotions should have positive consequences for intentions to persist.

Interpersonal Predictors of Weight Management Goals and Behaviors

Traditionally, health researchers have examined health behaviors and outcomes from the perspective of the individual. However, most goals and behaviors occur in a social context in which partners, friends, and family have the potential to influence their formation and maintenance (Fitzsimons & Finkel, 2010; Nielsen et al., 2018). While health behaviors and outcomes are shown to spread across social networks more broadly (e.g., obesity; Christakis & Fowler, 2007), romantic partners have even greater potential to influence each other's health because of their enduring influence and highly interdependent lives.

Romantic partners should affect each other's health behavior goals and outcomes for a few reasons. First, partners spend a great deal of time in each other's company—often times sharing a residence, pooling their resources, and sharing their social network (Huelsnitz, Rothman, & Simpson, 2018). They also share daily life activities and decisions about important health behaviors, such as eating, exercise, sex, and substance use. Indeed, research on newly cohabitating couples reveals an increase in joint meal planning and preparation (Anderson, Marshall, & Lea, 2004). Second, people should be particularly motivated to promote their partner's health because they are invested in their partner's long-term outcomes (Huelsnitz et al., 2018). With increased interdependence, partners' health behaviors and outcomes become increasingly likely to affect the self. For instance, partners' unhealthy behaviors could affect people's ability to meet their own health goals in the short-term or could lead health problems severe enough to necessitate

care in the long-term. Alternatively, people may be motivated to promote partners' health because they care about their partners' well-being (Crocker et al., 2018; Mikulincer & Shaver, 2010).

How do romantic partners influence weight management goal pursuit? Social and health psychologists have explored two primary ways partners influence one another's goals: Goal contagion and goal-relevant partner support. *Goal contagion* refers to the tendency for people to adopt a goal after observing another's behavior and inferring their underlying goal (Aarts, Gollwitzer, & Hassin, 2004; Laurin, 2016). The process by which others trigger goals and subsequent goal-oriented behavior largely occurs outside of one's conscious awareness. People are more likely to take on other's goals when they perceive the other pursuing a goal with great effort (Dik & Aarts, 2007), feel connected to the actor (Loersch, Aarts, Payne, & Jefferis, 2008), hold less power in the relationship (Laurin et al., 2016), and when the goal is compatible and not in conflict with their preexisting goals (Radel, Fournier, de Bressy, & d'Arripe-Longueville, 2015). Thus, it is likely that people's goal-directed weight management behaviors are partially due to the goal efforts of their romantic partners.

In addition to unintentional influence over partner's health behaviors through goal contagion, people may make more intentional attempts to change their partner's behaviors. Partners engage in a variety of behaviors with the intention of changing partner's behavior to align with beliefs or expectations of what one "should do" (Huelsnitz et al., 2018). *Social support* refers to the provision of emotional or instrumental assistance in times of need (Cohen, 2004), though, more specifically, *goal-relevant social support* refers to assistance provided with the intent of helping individuals

self-regulate more effectively (Fitzsimons & Finkel, 2010). For example, listening to a partner's concerns over treatment side effects or encouraging one's partner to stick with their exercise routine. Social support is found to benefit individuals' health broadly (Uchino, 2006; Uchino, Cacioppo, & Kiecolt-Glaser, 1996) and affects a variety of health behaviors, including sleep, diet, and smoking (Uchino, 2004).

The benefits of social support extend beyond specific health behaviors to affect goal pursuits (Fitzsimons & Finkel, 2010). In general, perceiving more responsive support from partners is beneficial for goal pursuit (Brunstein, Dangelmayer, & Schultheiss, 1996; Cohen & Wills, 1985; Feeney, 2004). Sometimes people attempt to get their partners to adopt a goal or pursue their current goal more vigorously (Overall, Fletcher, & Simpson, 2006). Nurturing and action-facilitating (vs. negative) support are perceived as more helpful, which in turn leads to greater self-improvement (Overall, Fletcher, & Simpson, 2010). While the strategies people choose to regulate their partner may be perceived as unsuccessful in the short-term, direct influence strategies tend to predict increased change over time (Overall, Fletcher, Simpson, & Sibley, 2009). Context-specific social support (versus global support) may also be more effective for partners' health behavior goals (Burkert, Knoll, Luszczynska, & Gralla, 2012).

Further research shows that merely thinking of partner's support boosts goal pursuit intentions and relying on others for help with own goal pursuit can be beneficial when resources are depleted (Briskin, Kopetz, Fitzsimons, & Slatcher, 2017). While research typically shows support facilitates goal pursuit, several studies have found contradicting evidence (Fitzsimons & Finkel, 2011; Kappes & Shrout, 2011). It is possible that perceptions of partners' intentions for goal support may determine whether

support is deemed responsive or not. Several studies have examined the impact of people's intentions on the effectiveness of their support. Support that is perceived to be motivated by care and concern are viewed as more effective in promoting health behavior change (Tucker & Mueller, 2000) versus those perceived as selfish or controlling (Ng, Ntoumanis, & Thorgersen-Ntouman, 2014; Thompson, Romo, & Dailey, 2013). Further, researchers have found that supporting a partner's goal can lead to progress toward one's own goal (Kumashiro, Rusbult, Wolf, & Estrada, 2006).

Extensive research demonstrates the effects of social support on health behaviors and outcomes more broadly (Uchino, 2004, 2006; Uchino et al., 1996), though much of this work has evolved without a strong theoretical foundation (Burke & Segrin, 2014). Thus, more work is needed on the underlying mechanisms explaining how and why goal-relevant social support affects people's health behaviors and outcomes. The current study draws on theory from relationship science, self-regulation, and health psychology to further understand these pathways.

Theoretical Framework for Investigating Close Relationships and Health

In recent decades, the fields of relationship science and health psychology have flourished, albeit, largely independent of one other (Pietromonaco et al., 2013). The merging of these two fields offers considerable benefits—relationship science offers strong theoretical frameworks and methodological paradigms and health psychology offers an opportunity for basic and applied research that can have widespread and meaningful impact. Pietromonaco and colleagues (2013) reflect that health psychology does not commonly utilize relationship science theories or methodologies to guide the development of study hypotheses, design, and methodology, despite frequent use of key

relationship variables. Attachment theory and interdependence theory are common theoretical frameworks that have guided a majority of research on close relationships and have strong implications for the promotion of health, wellness, and prevention of disease health.

To better understand the interpersonal processes through which close relationships influence health, Pietromonaco, Uchino, and Dunkel Schetter (2013) proposed a theoretical model integrating constructs and processes from relationship science with biopsychosocial processes. In this model, relationship orientations (e.g., attachment, interpersonal goals) are theorized to predict dyadic behaviors (e.g., support provision/receipt, social negativity) and processes (e.g., partner responsiveness, satisfaction). Dyadic behaviors and processes should in turn predict physiology, affect, and health behaviors, with subsequent implications for health and disease outcomes. Of importance, both positive and negative dyadic processes are included in the model because of their unique contributions to outcomes within the field of relationship science. For instance, constructive and destructive responses to partners' sharing of positive events predict unique variance in relationship quality (Gable, Reis, Impett, & Asher, 2004). In addition, dyadic processes can have a reciprocal association with a person's physiology, affect, and health behavior, as well as their health and disease outcomes.

Notably, the model includes pathways for both relationship partners, illuminating the ways in which each partner may influence the other at various points in the model. Most major theories of relationship science (e.g., interdependence theory), emphasize the dynamic and reciprocal nature of close relationships (Pietromonaco et al., 2013). While each partner's own characteristics have implications for the self, their partner's

characteristics (and the interaction between partners' characteristics) predict important outcomes. For example, a person's attachment style may affect their partner's responsiveness and relationship satisfaction or a person's chronic illness symptoms may affect their partner's stress response and health behaviors. Even when intervention studies involve patients' romantic partners, many do not measure important reactions and behaviors of the partner (e.g., Martire, Helgeson, & Saghafi, 2010) or consider the consequences of the interaction between actor's and partner's characteristics. Measuring each partners' variables is important because researchers may be missing significant variance in health behaviors or outcomes explained by the partner or the relationship.

Pietromanaco and colleagues' (2013) framework can be used to investigate important biopsychosocial processes and health outcomes. Researchers have identified a number of mechanisms through which close relationships affect health, that includes psychosocial pathways (e.g., emotion, cognition), biological pathways (e.g., immune, cardiovascular), and health and lifestyle pathways (eating, physical activity; Pietromonaco & Collins, 2017; Pietromonaco et al., 2013). While research has predominantly focused on the psychosocial and biological pathways linking close relationships to health (Robles et al., 2014), few studies have examined the behavioral pathways (Huelsnitz et al., 2018; Pietromonaco et al., 2013; Robles et al., 2014). Interpersonal influences on health behavior are ripe for exploration and intervention as health behaviors such as physical inactivity and poor diet strongly effect physical and psychological well-being (Johnson, Hayes, Brown, Hoo, & Ethier, 2014) and people have the potential to influence on their romantic partner's health behaviors (see Kiecolt-Glaser & Wilson, 2017 for review).

The Egosystem-Ecosystem Theory of Social Motivation

The current study examines Pietromonaco et al.'s (2013) model by exploring the influence of two interpersonal goals—compassionate and self-image goals—which have been shown to have strong and consistent implications for personal well-being and relationship functioning (Crocker, Canevello, & Brown, 2017). *Compassionate goals* involve being supportive and constructive in relationships with others out of concern for their well-being. People with compassionate goals see their needs as equal to others and believe that what is good for others is good for the self. *Self-image goals* involve constructing, maintaining, and defending a desired image of the self (Crocker & Canevello, 2008). People with self-image goals prioritize their own needs over others' and see one's own needs in competition with others.

The egosystem-ecosystem theory of social motivation is an ideal theoretical perspective to examine using Pietromonanco and colleagues' (2013) model because of its immerging prominence in relationship science and explanatory power for a wide range of intrapsychic and relational processes. With its clear relevance to health, Crocker and Canevello's egosystem-ecosystem theory has the potential to generate a number of interesting hypotheses related to health behavior and outcomes (see Canevello & Crocker, 2011 for review). Individual differences in relational orientations should shape how people approach health behaviors and outcomes. For example, individuals with chronically high self-image goals may be more prone to engaging in risky health behaviors such as drinking, smoking, or having unprotected sex, because of their self-presentation concerns. Further, given the strong interpersonal consequences of relational orientations, interpersonal goals should also emerge as key predictors for partners'

influence over one another's health behaviors and outcomes. For example, people with the goal to support others' well-being may provide more responsive support for their partner's weight loss goal or during chemotherapy treatment. The malleability of interpersonal goals may be particularly valuable for future interventions seeking to modify important health processes.

Ecosystem Motivation Orientation. The ecosystem is a motivational system where the self is construed as one part of a larger system of interconnected people (Crocker, Olivier, & Nuer, 2009). In this perspective, individuals' actions affect one another and have repercussions for the system as a whole, affecting their abilities to meet their needs. In the ecosystem, people see their own needs and desires as having equal importance to those of others. To that end, people view their relationships as non-zero-sum, such that the well-being of one partner does not have to come at the expense of the other. They understand that what's good for the partner is good for the self. For the relationship to function, both people must have their needs and desires met. Therefore, the extent to which one's needs are being met and the other's are not, the system breaks down.

In the ecosystem, people treat their own and others' needs and desires as equal because they understand that they are part of a larger whole (Crocker & Canevello, 2015). They prioritize the needs and well-being of others—not out of selflessness or sacrifice, rather because they care about the person and their outcomes. Relationship partners' needs and desires become part of a synchronous and mutually interdependent system (Crocker et al., 2009). Here, people trust that their needs can be met in a way that also benefits others and not that something must be given up from that other. Therefore,

they believe that needs can be met in collaboration rather than competition with the other. In addition, when people have ecosystem motives they view the self as the source of their experiences within the relationship or the starting point for processes that lead to relationship flourishing. Further, they understand that one's own actions can positively or negatively impact the relationship (Crocker et al., 2009).

In the ecosystem, relationships flourish in moments of vulnerability; such that people encourage trust and love by demonstrating each (Reis, Clark, & Holmes, 2004). Connectedness to others and support are reciprocally related—people feel close to others who are considered responsive (LeMay, Clark, & Feeney, 2007) and closeness promotes support provision (Brown & Brown, 2006). Therefore, people function in the relationship to promote their partner's well-being rather than depending on the partner to fulfill needs. For example, commitment deepens when people focus on improving the relationship for the good of each person, rather than desire to make it last. When interacting with others, people in the ecosystem tend to form compassionate goals, or the desire to be supportive and constructive out of care for others' well-being (Crocker & Canevello, 2008).

Egosystem Motivational Orientation. The egosystem is a motivational system that is focused on the self. In this system, people are most concerned with getting their own needs and desires met (Crocker & Canevello, 2015). People view their relationships with others as competitive or zero-sum, such that one's needs can only be met at the expense of others (Crocker et al., 2009). Here, people evaluate and judge others, as well as the self, and anticipate that they are being evaluated and judged by others. Concern with other's impressions of the self leads people to focus on demonstrating desired

qualities and hiding undesirable qualities. In general, people do not consider how their behavior influences the situation or affects others.

In this system, people prioritize their own needs over others. They don't attend to the needs or desires of others, because others' needs are not as important as their own. From this perspective, people focus on others to the extent that the other may give or withhold something that they want—recourses such as approval, inclusion, or validation (Crocker & Canevello, 2015). As such, people spend a great deal of their time seeking benefits for the self that come from relationship partners. Broadly, this orientation is associated with desires to maximize gains and minimize losses for the self. In the egosystem, people also find themselves feeling at the mercy of the relationship partner—holding the perspective that they need others to meet their needs.

From this perspective, relationships are valued because of the opportunities provided for resources to flow from the partner to the self. Ultimately, people are not concerned with others' well-being; which is evident through their prioritization of their own needs and desires over those of others (Crocker & Canevello, 2012a). In general, the relationship quality is evaluated based on the benefits the relationship provides the self. Specifically, people are concerned with what their involvement in the relationship communicates about them to others.

When interacting with others, people with an egosystem orientation tend to have self-image goals—they attempt to make others see them more positively—having desired qualities, but not undesirable qualities—to improve their chances of getting what they want (Crocker & Canevello, 2015). In addition, people put their energy into proving themselves to others and confirming that others hold them in high regard (Crocker, 2008;

Crocker & Canevello 2012a; Crocker et al., 2009). To do so, people engage in impression management and utilize a variety of strategies to influence other's opinions of the self (e.g., persuasion, ingratiation, intimidation; Crocker & Canevello, 2012a).

The Hypothesized Model

The present research examines the intrapersonal and interpersonal processes of weight management goal pursuit and contributes to those literatures in several important ways. This project is an important first step in linking interpersonal goals to health behaviors and responds to a call for research that incorporates theory and methodology from relationship science into the study of health and well-being (Pietromonaco et al., 2013). Specifically, it is the first empirical study to examine health goal striving using the egosystem-ecosystem theory of social motivation, a robust theoretical perspective with implications for psychological, physical, and relational well-being.

In addition to a strong theoretical foundation, this project explores affective processes as mechanisms for understanding the intrapersonal and interpersonal pathways to health goal striving—building on existing knowledge stemming from theories of self-regulation (Mann et al., 2013) and filling important gaps in our understanding of the affective mechanisms linking close relationships and health (Farrell et al., 2018). Ultimately, this research is novel in its investigation of individual differences in relational orientations, use of dyadic methodologies, and inclusion of explanatory mechanisms with substantial potential to contribute to disease prevention and behavioral health intervention efforts.

Figure 1 illustrates a model derived from Pietromonaco et al.'s (2013) theoretical framework. Specifically, the hypothesized model focuses on associations between the

following components of Pietromonaco et al.'s model: relationship orientations (i.e., interpersonal goals), relationship behavior (i.e., partner support), affect (i.e., emotional responses to goal setbacks and progress), and health behavior (i.e., weight management intentions to persist). Notably, this model also examines associations between both romantic partners. This model elucidates two pathways through which compassionate and self-image goals influence weight management goal persistence. First, the model depicts an *intrapersonal* pathway whereby interpersonal goals are expected to predict *own* persistence at a weight management goal (Paths A-C). Second, the model depicts an *interpersonal* pathway whereby interpersonal goals are expected to predict *partners'* intentions to persist (Paths D-G).

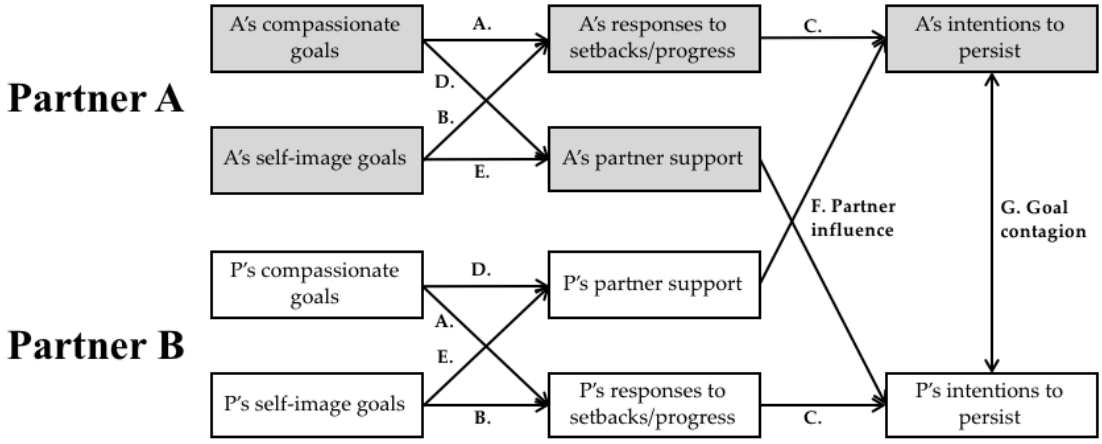

Figure 1. Hypothesized theoretical model outlining the intra- and interpersonal pathways linking interpersonal goals to intentions to persist.

Intrapersonal Processes: Actors' Compassionate and Self-Image Goals Predict Actors' Regulation of Weight Management Goals

I hypothesize an intrapersonal model examining how people's compassionate and self-image goals shape their regulation of weight management goals. This work extends

previous research by examining the health behavior change process utilizing theory from the fields of social psychology and relationship science (Huelsnitz et al., 2018; Mann et al., 2013; Pietromonaco et al., 2013). Paths A-C in Figure 1 show the first hypothesized intrapersonal pathway: actors' interpersonal goals predict actors' emotional responses to goal setbacks and progress (Paths A-B) that, in turn, predict actors' intentions to persist (Path C). Paths A-C are mirrored for partners in the lower portion of the figure, appearing as covariates in interpersonal analyses described in greater detail below.

Here I present rationale for each hypothesized pathway appearing in the intrapersonal model.

***Path A: A's compassionate goals predict A's emotional responses to goal setbacks and progress*—**I hypothesize that compassionate goals shape people's emotional experiences in response to goal setbacks and progress. Early theorizing from Crocker, Moeller, and Burson (2010) supports much of this claim. In their review of the self-regulation literature, Crocker and colleagues suggest compassionate goals should activate a "warm" self-regulatory system characterized by positive, calm, other-directed emotional responses. In the warm system, people feel clear and connected during their interactions with others, rather than afraid and confused. Like Metcalfe and Mischel (1999)'s "cool" system, the warm self-regulatory system is theorized to facilitate goal pursuits by maintaining focus on important goals and monitoring their progress. Further support is provided by the notion that compassionate goals foster connection to a larger existence without ego-involvement, thus, helping people see beyond the self (Crocker, Niiya, & Mischkowski, 2008). When people have compassionate goals they maintain a learning orientation, such that they construe setbacks as opportunities for growth instead of

dwelling on what the setback says about the self (Crocker et al., 2007; Crocker & Park, 2004). Thus, people with compassionate goals should not experience intense, emotional highs following their successes or lows following their failures; they see the world as bigger than the self and see failures as an opportunity to learn and expand the self.

When faced with setbacks during goal pursuit, those with the goal to support others should report feeling *human, realistic,* and *authentic* because of their broader, long-term perspective of the human experience and ability to put setbacks into perspective (Crocker & Canevello, 2015; Crocker et al., 2009). Setbacks are not interpreted as failures, rather they are viewed with self-compassion as normative bumps in the road of goal pursuit. To those with compassionate goals, setbacks are non-threatening to the self and prompt cognitive and behavioral responses marked by self-compassion, flexibility, and growth. When faced with progress during goal pursuit, those with compassionate goals should report feeling *humble, fallible*, and *curious* for similar reasons. Progress is not interpreted with a strong focus on the self, rather those with compassionate goals make more balanced attributions about their successes. To those with compassionate goals, progress signals positive movement toward one's goal and prompts cognitive and behavioral responses marked by acknowledgement of their successes and curiosity toward the goal striving process.

Consistent with these hypotheses, compassionate goals have been linked to a number of relevant constructs. People high in compassionate goals report greater spiritual transcendence, feeling a deep sense of connection to and responsibility for other living things and people outside of their group (Crocker & Canevello, 2008). They report greater self-compassion, such that they are high in self-kindness and low in self-

judgement (Crocker & Canevello, 2008). They tend to be high in growth-seeking (Niiya et al., 2013) and show a learning orientation, reporting greater motivation to grow and learn from failure (Niiya & Crocker, 2007). Compassionate goals are also associated with greater self-regulation of academic and friendship goals, a link that is mediated by feeling clear and connected about one's goal (Moeller, Crocker, & Canevello, 2008, Study 1). Finally, Moeller and Crocker (2008) examined the impact of feeling clear and connected on emotional responses to self-improvement goal setbacks. Feeling connected at baseline predicted feeling more human in response to setbacks one week later, which in turn, predicted more progress the following week.

Analysis of data from the *Goals and Adjustment to College Study* (Canevello & Crocker, 2007; Crocker & Canevello, 2010; Crocker, Niiya, & Luhtanen, 2007) lends strong support to the current hypotheses. Interpersonal goals and emotional responses to goal setbacks and progress in academic goals were assessed each week for 10 weeks in a study of 199 first-semester college students. First, I examined the impact of individual differences by testing whether chronic compassionate goals predicted chronic emotional reactions to academic goal setbacks and progress. As hypothesized, chronic compassionate goals were positively associated with humble responses to progress, ß = .25, $t(193) = 3.86$, $p < .001$, and human responses to setbacks, ß = .32, $t(193) = 4.74$, $p < .001$. This pattern suggests that those with compassionate goals tend to experience low intensity emotional responses (e.g., humble, human) during goal pursuit.

Analyses were also conducted to examine whether weekly fluctuations in compassionate goals predict emotional responses to setbacks and progress that week. As hypothesized, on weeks when people had higher compassionate goals than their average,

they experienced greater humble responses to goal progress, $b = .17$, $t(1607.19) = 4.02$, $p < .001$, and greater human responses to goal setbacks, $b = .19$, $t(1645.59) = 4.07$, $p < .001$, when controlling for self-image goals, amount of progress and setbacks, and the parallel emotional response (i.e., empowered and ashamed responses, respectively). These results replicate those shown in the chronic analyses above and expand upon those by providing evidence that fluctuations from one's normal level of compassionate goals are linked to changes in people's emotional responses.

***Path B: A's self-image goals predict A's emotional responses to goal setbacks and progress*—**I hypothesize that self-image goals also shape emotional experiences in response to goal setbacks and progress. Again, I draw on Crocker, Moeller, and Burson's (2010) theorizing to support this claim. Self-image goals may lead to prioritization of constructing and maintaining a desired appearance over reality. Thus, those high in self-image goals might be reluctant to seek help or reveal their shortcomings to others in order to protect their image. Saving face in the short-term may have long-term costs for people's goal pursuits. Accordingly, self-image goals should activate a "hot" self-regulatory system (Metcalfe & Mischel, 1999), characterized by intense, negative, self-directed emotional responses. For example, in the hot system, people feel afraid and confused during their interactions with others. Concern over others discovering one's weaknesses or behaviors that conflict with one's desired image may lead those with self-image goals to experience anxiety (Leary, 1983). Experiences of negative self-relevant affect in response to setbacks may interfere with goal striving, leading people to abandon important goals. Ultimately, people with self-image goals should experience intense,

emotional highs following their successes and lows following their failures; they struggle to see past their immediate situation and see failures as threatening to their sense of self.

When faced with setbacks during goal pursuit, those with the goal to maintain a desired image of the self should report feeling *ashamed, weak,* and *inferior* due to their short-term, self-centered perspective of the human experience and difficulty putting setbacks into perspective (Crocker & Canevello, 2015; Crocker et al., 2009). To those with self-image goals, setbacks are interpreted as failures that interfere with their goals for maintaining a positive outward image of the self, thus, evoking shame. When faced with progress during goal pursuit, those with self-image goals should report feeling *powerful, proud,* and *admirable* for similar reasons. Progress is interpreted through a competitive lens and drives responses that are boastful and comparative in nature, such as pride (Lazarus, 1991). To those with self-image goals, progress is attributed to stable, internal forces that may contribute to inflated views of the self and over-celebration of one's success.

Consistent with these hypotheses, self-image goals have been linked to a number of relevant constructs. People high in self-image goals report less self-compassion, such that they are low in self-kindness and high in self-judgement (Crocker & Canevello, 2008). They tend to show a performance orientation, reporting greater motivation to demonstrate intelligence and decreases in their desire to learn from failure (Niiya & Crocker, 2007). Self-image goals are also associated with worse self-regulation of academic and friendship goals, a link that is mediated by feeling afraid and confused about one's goal (Moeller, Crocker, & Canevello, 2008, Study 1). Further, Moeller and Crocker (2008) examined the impact of feeling afraid and confused on emotional

responses to self-improvement goal setbacks. Feeling afraid at baseline predicted feeling more powerless in response to setbacks one week later, which in turn, predicted more setbacks the following week.

Analyses from the *Goals and Adjustment to College Study* described in greater detail above provide some preliminary support for these hypothesized pathways. First, I examined the impact of individual differences by testing whether chronic self-image goals predicted chronic emotional reactions to academic goal setbacks and progress. As hypothesized, chronic self-image goals were positively related to empowered responses to progress, $\beta = .21$, $t(193) = 3.51$, $p = .001$, and ashamed responses to setbacks, $\beta = .35$, $t(193) = 5.44$, $p < .001$. Thus, those with self-image goals experienced intense emotional responses (e.g., empowered, ashamed) during goal pursuit.

Analyses were also conducted to examine whether weekly fluctuations in self-image goals predict emotional responses to setbacks and progress that week. As hypothesized, on weeks when people had higher self-image goals than their average, they experienced greater empowered responses to goal progress, $b = .30$, $t(1666.01) = 6.03$, $p < .001$, and greater ashamed responses to goal setbacks, $b = .10$, $t(1712.58) = 2.06$, $p = .04$, when controlling for the same variables listed above. These results replicate those shown in the chronic analyses above and expand upon those by providing evidence that deviations from one's normal level of self-image goals are linked to changes in people's emotional responses.

***Path C: A's emotional responses to goal setbacks and progress predict A's intentions to persist*—**I hypothesize that emotional responses to setbacks and progress—two common experiences of goal striving—influence people's persistent effort toward weight

management goals. As stated earlier, emotions function to motivate, direct, and regulate goal-directed behavior in pursuit of important goals (Bagozzi, Baumgartner, & Pieters, 1998). Although little empirical evidence exists regarding the impact of discrete emotions on subsequent goal striving, some early theorizing on affect described in detail above lends support to *how* and *why* emotions impact intentions to persist.

I hypothesize that feeling *human, realistic,* and *authentic* in response to goal setbacks promote intentions to persist. Experiencing this set of "warm," positive emotions should lead to continued persistence for one's weight-management goal, as people take a kind and accepting approach toward the self, preserving their motivation to persist. The self-compassion literature provides some insight into this hypothesis, as self-compassion has been shown experimentally to promote motivation for self-improvement and persistence for problem-solving (Breines & Chen, 2012).

In contrast, I predict that feeling *ashamed, weak,* and *inferior* in response to goal setbacks have a negative impact on goal striving. Experiencing this set of "hot," negative emotions in response to setbacks may cause individuals to abandon their goal in an attempt to reduce current unpleasant emotions and avoid the reoccurrence of such emotional states. People should be highly motivated to reduce emotions that are particularly intense and uncomfortable, such as shame and embarrassment; essentially prioritizing the short-term reduction in negative affect over their long-term goals. Indeed, research suggests that shame after a dieting transgression predicts diet discontinuation (Thompson, Altmann, & Davidson, 2004).

While some evidence exists for consequences of emotional responding to setbacks, a more novel line of inquiry involves examining the impact of emotional

responses to goal progress. I hypothesize feeling *humble, fallible*, and *curious* in response to goal progress leads to intentions to persist. Experiencing this set of "warm," positive emotions should lead to continued persistence for one's weight-management goal, as people maintain consistent motivation and realistically appraise the distance to meeting their goal. Indeed, similar externally-focused emotions, like gratitude, have been linked to goal progress (Emmons & Mishra, 2011) and, experimentally, to increases in health behaviors (i.e., exercise; Emmons & McCullough, 2003).

In contrast, I hypothesize feeling *proud, strong,* and *admirable* leads to goal abandonment. Experiencing this set of "hot" positive emotions may lead to a reduced effort because people believe they have made satisfactory progress in pursuit of their goal (Fishbach & Dhar, 2005). Thus, when people feel empowered in response to progress they might grant themselves slack for their current goal or turn their attention to other goals, even when they are not done pursuing the current goal. Another reason feeling empowered may lead to goal abandonment is self-licensing, a process where individuals engage in excessive rewarding of the self in response to progress (Prinsen, Evers, & de Ridder, 2016) found to increase future indulgence and goal lapse. Indeed, pride is associated with an overconfidence about one's control efficacy that exposes the self to temptation (Nordgren, van Harreveld, & van der Pligt, 2009).

Further analysis of data from the *Goals and Adjustment to College Study* lends support for these hypothesized pathways. I conducted lagged-week analyses where I examined whether emotional responses to academic goal setbacks and progress at Week 1 predicted change in goal progress or setbacks from Week 1 to Week 2. Notably, although the hypothesized model predicts the impact of emotional responses to setbacks

and progress on intentions to persist (i.e., future goal-directed effort), this variable was not measured in their dataset. Therefore, future setbacks and progress were used as proxies for intentions to persist in this set of analyses.

First, I examined the impact of low intensity emotional responses on future progress and setbacks. Feeling more humble in response to progress at Week 1 did not predict change in progress, b = -.02, t(727.68) = .01, p = .99, and predicted decreased setbacks, b = -.07, t(704.44) = -2.11, p = .04, from Weeks 1 to 2. Interestingly, feeling more human in response to setbacks at Week 1 predicted increases in both progress b = .06, t(789.77) = 1.94, p = .05, and setbacks b = .07, t(763.83) = 2.36, p = .02, from Weeks 1 to 2. The findings reveal that feeling human in response to setbacks was related to increases in both progress and setbacks. It is possible that feeling human may lead to greater, and more varied, goal-directed behavior, as testing a wide range of strategies may result in an increase in successes and failures.

Next, I examined the impact of high intensity emotional responses on future progress and setbacks. Feeling more ashamed in responses to setbacks at Week 1 marginally predicted people's decreased progress, b = -.05, t(733.96) = -1.87, p = .06, and predicted their increased setbacks, b = .07, t(716.12) = 2.16, p = .03, from Weeks 1 to 2. Feeling more empowered in response to progress at Week 1 marginally predicted their increased progress, b = .05, t(683.75) = 1.87, p = .06, and did not predict change in setbacks, b = -.01, t(666.44) = -.37, p = .71, from Weeks 1 to 2. Of particular interest, the findings reveal that feeling empowered in response to progress led to more progress. This may be explained by the varied conceptualizations of pride, as research in the emotions literature often differentiates between authentic (e.g., fulfilled, productive) and hubristic

pride (e.g., arrogant, conceited; Tracy & Robins, 2007). Authentic pride is positively associated with self-control, attention control, and conscientiousness whereas hubristic pride is inversely related to this set of goal-relevant constructs (Carver, Sinclair, & Johnson, 2010).

Interpersonal Processes: Partners' Compassionate and Self-Image Goals Predict Actors' Regulation of Weight Management Goals

In addition to the hypothesized intrapersonal model, I hypothesize an interpersonal model examining how people shape their partner's weight management goals and resulting health behaviors. This research extends prior work on interpersonal processes by simultaneously examining the effects of implicit and explicit forms of social influence: goal contagion and goal-relevant partner support. Figure 1 shows the hypothesized interpersonal pathways: partner's compassionate and self-image goals predict partner's support (Paths D-E), which should, in turn, predicts actor's intentions to persist (Path F). Further, we test an alternative interpersonal pathway, whereby partner's intentions to persist predicts actor's intentions to persist (Path G), a process known as goal contagion. Paths D-G appear for both partners in the hypothesized model.

***Paths D-E: P's compassionate and self-image goals predict P's partner support*—**I hypothesize that interpersonal goals shape partner support for weight management goals. When people hold compassionate goals, they focus on supporting others out of concern for their well-being; wanting to be constructive, and not harmful, presence in their relationships (Crocker & Canevello, 2008). This concern for others' needs should foster greater responsiveness in their interactions with others. Because of the importance of physical health for broader psychological, emotional, and relational functioning (e.g.,

Cho et al., 2011), compassionate goals should be especially predictive of responsive partner support in the context of weight management goals. When people hold self-image goals, they support others to the extent that it benefits the self; focusing on what others think of them and not what others need. This focus on the self should undermine responsiveness in their interactions with others. Partners' weight management goals may provoke self-relevant thoughts, insecurity, and social comparison surrounding outward appearance and health standards, making self-image goals particularly predictive of less responsive partner support for weight management goals.

I hypothesize that people with compassionate goals should respond to their partners' health behavior goals in supportive ways, whereas self-image goals should undermine the provision of effective support for partners' goals. Existing literature suggests that people with compassionate goals report being and are perceived as more supportive (Crocker & Canevello, 2008) and responsive (Canevello & Crocker, 2010) in their interactions with close others. In general, those with compassionate goals are better at identifying and giving support that fits partners' needs (Lee et al., 2017). Self-image goals are associated with less support for others (Crocker & Canevello, 2008; see Crocker & Canevello, 2016, for a review). Further, compassionate and self-image goals interact to predict support, such that people low in self-image goals and high in compassionate goals provide greater support to friends and romantic partners. Being high in self-image goals does not lead to increases in social support, even when people are high in compassionate goals (Crocker & Canevello, 2008).

Path F: P's support predicts A's intentions to persist—When partners provide responsive support for individuals' personal goal strivings, individuals experience greater

goal-related self-efficacy (Feeney, 2004). Further, greater partner responsiveness during discussions of self-improvement goals has been shown to predict goal accomplishment six months later (Feeney, 2007). Indeed, individuals find their partners more helpful and are more successful in achieving self-improvement goals when their partners provide nurturing and action-facilitating partner support (Overall et al., 2010). Therefore, I predict partners' responsive support to positively impact actors' intentions to persist.

Path G: P's intentions to persist predicts A's intentions to persist—Finally, I hypothesize that partners' intentions to persist should positively relate to actors' intentions to persist. At least some of the variance in health behaviors can be attributed to a concordance between romantic partners (Meyler, Stimpson, & Peek, 2007). Further, behavioral weight loss treatment for one partner tends to have beneficial consequences for the other, untreated partner (Gorin et al., 2008). This may be partially due to goal contagion, the tendency for people to "catch" and subsequently pursue the goals of those around them (Aarts, Gollwitzer, & Hassin, 2004; Laurin, 2016).

The Current Research

My dissertation tests the hypothesized model in a normative (i.e., nonclinical) sample of romantic couples in which both partners have a current weight management goal to decrease or maintain their body weight. The intrapersonal pathway in the model examines how people's chronic compassionate and self-image goals predict their emotional responses to goal progress and setbacks, which in turn, predict their intentions to persist at their weight management goal. Further, I examine how people's compassionate and self-image goals predict their use of partner support strategies. This model also examines a second, interpersonal pathway to goal persistence, where partner's

support predicts people's weight management intentions to persist. The impact of competing forms of partner influence (goal contagion vs. goal-relevant partner support) on intentions to persist are also examined at this time.

After exploring primary hypotheses, I also examine a number of alternative explanations that may account for the intra- and interpersonal pathways linking interpersonal goals to intentions to persist. Because there are strong social norms and stigma surrounding weight management and relationship behaviors, social desirability may affect how people respond about their own and their partner's goals. When people are depressed, they may be pessimistic around goal pursuit and more likely to disengage when setbacks arise (Dickson, Moberly, O'Dea, & Field, 2016). Further, it may hinder their ability to provide goal-seeking partners with effective support. Disordered eating symptoms could affect intrapersonal pathways, given the tendency for those with eating disorders to experience emotion regulation difficulties (i.e., non-acceptance of negative emotions, lack of emotional clarity, difficulty employing goal-directed behavior; Harrison et al., 2010) and lower emotional well-being (Mond et al., 2005). Goal importance may influence the intensity emotions and cognitions in responses to goal-relevant events, contributing to emotional responses and intentions to persist. Likewise, the amount of setbacks or progress people appraise may influence emotional responses and decisions to persist. Attachment styles have important implications for self-regulation (Blalock, Franzese, Machell, & Strauman, 2015) and partner regulation (Overall & Simpson, 2015), which might contribute to the regulation of weight management goals. People with more satisfying relationships may have more success during goal pursuit (Hofmann, Finkel, & Fitzsimons, 2015) and provide higher quality support than their less

satisfied counterparts. Finally, simply being aware of and valuing their partners' goals may cause people to provide greater support. It may be the case that some of the predicted associations are explained by these factors, given their established links to compassionate and self-image goals (Crocker & Canevello, 2008; 2012).

I also assess a number of theoretically meaningful moderators of the intra- and interpersonal pathways. It is possible that emotional responses to goal setbacks and progress and subsequent intentions to persist vary as a function of characteristics of the individual and the goal. Further, a number of variables may moderate interpersonal pathways linking interpersonal goals to partner support and, in turn, to intentions to persist. First, given the variations in age due to my sampling method, which involved recruiting students and community members, I test whether intrapersonal and interpersonal effects differ by age.

Participants' sex might also affect their regulation of weight management goals, given differences in men and women's eating behaviors and weight regulation (Rolls, Fedoroff, & Guthrie, 1991). Further, sex is found to affect support processes, such that women are found to provide support that is more responsive and better timed (Cutrona, 1996; Neff & Karney, 2005) and men are found to benefit more from social support (Scholz et al., 2013).

Next, those at a higher Body Mass Index (BMI) might experience amplified emotional responses to setbacks and progress and varying levels of weight management intentions to persist. According to Jorm et al. (2003), obesity is related to increased negative emotions, higher rates of depression, and decreased positive emotions. In addition, people with obesity tend to have lower perceived self-efficacy for a variety of

health behaviors, including dietary intake (Richman, Loughnan, Droulers, Steinbeck, & Caterson, 2001) and exercise (Stutts, 2002). Both partners' BMI should also have important implications for interpersonal processes given the likelihood of social comparison. Actors' and partners' BMI might moderate associations between partners' interpersonal goals and their partner support and partners' provision of partner support and their intentions to persist may differ, given the greater conflict found in mixed-weight couples (Burke, Randall, Corkery, Young, & Butler, 2012).

Third, the types of goals participants are pursuing could explain some of the predicted pathways. Those who have the goal to decrease or maintain their weight may set fundamentally different goals, pursue their goals using different strategies, and employ different self-regulation strategies during goal. Of greatest relevance, people with the goal to decrease their weight may experience more intense emotional reactions to goal setbacks and progress than those with the goal to maintain their weight. Such variations in emotional responses may have differing consequences for intentions to persist. Actors' goal type might also influence the support partners provide them, such that those pursuing weight loss goals are may need greater support than those pursuing maintenance goals.

Fourth, it is possible that those who have been pursuing weight management or loss for longer periods of time may have stronger emotional reactions to goal setbacks and progress and show variance in their persistent efforts during their current attempt. Therefore, I test whether actors' prior goal history moderates the intrapersonal pathways. Further, partners' influence on actors' intentions to persist may vary based on the actors' goal history. Actors with long histories of weight management goal pursuit may have

partners who are better attuned to their needs than those who are just beginning the weight management process.

Finally, it is possible that the amount of progress or setbacks experienced moderate intrapersonal pathways. Those experiencing more progress may experience more intense emotional responses to progress than those experiencing less progress. Likewise, those experiencing many setbacks may experience more intense emotional responses to setbacks than those experiencing fewer setbacks. Amount of progress or setbacks may also change how these emotional responses impact intentions to persist.

CHAPTER 2: METHOD

Participants

Seventy-one heterosexual romantic couples were recruited for a study of "close relationships and health behaviors." The desired sample size of 89 couples, needed to detect small-medium actor and partner effects (Ackerman & Kenny, 2016; Kenny, Kashy, & Cook, 2006), was almost achieved during the recruitment period. To participate, partners had to meet the following inclusion criteria: 18 years or older; in an exclusive, (heterosexual) romantic relationship of at least 6 months; have a current weight loss or maintenance goal; a BMI between 18.50 and 34.99; and no history of a clinically diagnosed eating disorder.

Participants ranged in age from 18-72 years (M = 30.99, SD = 12.99). The racial composition of the sample was 77.5% White, 8.5% Hispanic/Latino/a, 7.7% Black, 3.5% Bi/Multiracial, and 2.8% Asian. Subjective social status was reported using the MacArthur scale (Adler, Epel, Castellazzo, & Ickovics, 2000), with responses ranging from 1-10 (M = 7.08, SD = 1.49). Participants' educational backgrounds varied: 16.2% completed high school, 2.8% attended vocational/tech school post high school, 31.7% completed some college, 28.2% received their bachelor's degree, 16.9% received their master's degree, and 4.2% received their doctoral degree.

On average, participants reported a Body Mass Index of 26.18 (SD = 3.78). According to NIH categories, this converts to: 41.1% Normal weight, 46.1% Overweight, 12.8% Obese 1. Most participants reported pursuing a weight loss (80.9%) vs. a weight maintenance goal (19.1%). Finally, participants reported having had their current weight management goal for an average of 2.04 years (SD = 3.54). Relationships ranged in

length from 6 months to 44 years, averaging 6.22 years in length (*SD* = 8.78 years). Further, 50.7% of couples were exclusively dating, 8.5% were engaged, and 40.8% were married or in a civil union/domestic partnership. Finally, 60.6% of couples in the current sample were cohabitating, whereas 39.4% were not.

Procedure and Materials

Prospective couples were approached in public locations on the UNC Charlotte campus and in the Greater Charlotte area about participating in a 30-minute study. Recruitment targeted couples where a) the researcher(s) could easily identify pairs, b) people might have some free time, and c) people would not be highly engrossed in activity. From these efforts, 32.4% of couples were recruited on campus and 67.6% from the greater Charlotte community (33.8% from parks/gym, 19.7% local festivals/events, 14.1% breweries/coffee shops). When a couple showed interest in the study, each partner completed an eligibility screener via Qualtrics. Due to the sensitivity of the screener questionnaire, ineligible couples were not informed why they did not qualify.

Couples who qualified were consented and received study materials. Partners wrote their goals on notecards in response to the following instructions: "Thinking about your desire to manage your current weight: 1) What was your main goal in the past month? 2) How did you try to meet that goal? Please provide a detailed description on the index card provided by the researcher." Then, partners completed measures about their weight management goal, emotional responses to goal progress and goal setbacks, and intentions to persist. Next, partners read the cards that had their partners' weight goals and answered questions about their partners' goal and support. Finally, they completed measures of their compassionate and self-image goals, attachment, relationship

satisfaction, depressive symptoms, disordered eating symptoms, and social desirability. Questionnaire blocks were counterbalanced and items randomized to control for the possibility of order effects. At the end of the survey, participants were debriefed and thanked for their time. Each couple received a $10 gift card for Starbucks or other local retailers for their participation in the study.

A number of goal characteristics were measured that could account for the effects of compassionate and self-image goals and emotional responses on intentions to persist. First, participants rated their *history of effort* for pursuing similar weight management goals: "How much have you attempted to achieve similar weight management goals in the past?" on a scale from 1 (*not at all*) to 7 (*a great deal*). Participants also answered questions about *goal importance* ("How important was your goal?") and the *amount of goal progress* and *setbacks* they experienced ("How much progress did you make in pursuing your weight management goal?" and "How much did you experience setbacks in pursuing your weight management goal?"). These three items began with the stem "Over the past month:" and were rated on a scale ranging from 1 (*not at all*) to 5 (*extremely*).

Emotional responses to goal progress were measured with a modified version of Crocker and Canevello's unpublished scale. Items began with the stem: "To what extent did your *progress* in pursuing your weight management goal make you feel:" and were rated on a scale ranging from 1 (*not at all*) to 5 (*very much*). *Humble* responses were measured on a 4-item subscale with the following items: "fallible," "curious," "humble," and "compassionate." *Empowered* responses were measured on a 6-item subscale with items that include: "strong," "powerful," "proud," "in control," "joyful," and

"admirable." Composite measures of *humble* and *empowered* responses to goal progress were created by averaging items for each subscale. Humble responses to progress demonstrated adequate reliability (α = .66), whereas empowered responses to progress demonstrated excellent reliability (α = .92).

Emotional responses to goal setbacks were measured with a modified version of Crocker and Canevello's unpublished scale. Items began with the stem: "To what extent did your *setbacks* in pursuing your weight management goal make you feel:" and were rated on a scale ranging from 1 (*not at all*) to 5 (*very much*). *Human* responses were measured on a 5-item subscale with items that include: "human," "realistic," "authentic," determined," and "responsible." *Ashamed* responses were measured on a 7-item subscale with the following items: "ashamed," "weak," "powerless," "out of control," "inferior," "critical of myself," and "victimized." Composite measures of *human* and *ashamed* responses to goal setbacks were created by averaging items for each subscale. The subscales demonstrated good reliability in the current study (human responses to setbacks, α = .75; ashamed responses to setbacks, α = .88).

Intentions to persist were measured with 10 items created for the current study. Items were presented in response to the following stem: "Over the NEXT MONTH, how likely are you to:" and rated on a scale ranging from 1 (*not at all likely*) to 7 (*very likely*). Items included: "work hard toward your goal?," "be diligent in pursuing your goal?," "get distracted by new ideas and projects while pursuing your goal?," "stick with your goal?," "have difficulty maintaining focus on your goal?," "make/maintain progress toward your goal?," "be discouraged by setbacks while pursuing your goal?," "choose to pursue a different goal instead of your current goal?," "lose interest in your goal?," and

"abandon your goal?." Items were averaged to form a single composite score for a scale with good internal consistency (a = .85).

Characteristics of the partner's goal that might account for interpersonal effects of the goals were also included. *Awareness of partner's goal* was measured with three items written for the current study: "How clear was your partner's goal to you?," "How aware were you of your partner's goal?," and "How much did you and your partner discuss his/her goal?." *Value of partner's goal* measured with a single item: "How much did you value your partner's goal?." All items began with the stem "Over the past month:" and were rated on a scale ranging from 1 (*not at all*) to 5 (*extremely*). Awareness of partner's goal demonstrated excellent reliability (a = .92).

Goal-relevant partner support was measured with a modified version of Overall, Fletcher, and Simpson's (2010) support for personal goals measure. The current study used two of the three facets of goal support identified by Overall et al.: nurturant and action-facilitating support. Items began with the stem "In the past month:" and were rated on a scale ranging from 1 (*not at all*) to 5 (*very frequently*). Participants completed 4 items pertaining to nurturant support (e.g., "I comforted my partner when he/she was feeling down about his/her goal") and 4 items pertaining to action-facilitating support (e.g., "I offered to work together with my partner to meet his/her goal"). Given the strong correlation between facets (pr = *.48,* $p < .001$) and lack of domain specific hypotheses in the current study, a single composite measure was created by averaging items across both facets of support. The scale demonstrated good internal consistency in the current study (a = .85).

Compassionate and self-image goals for participants' relationships with their

romantic partners were measured with a modified version of Crocker and Canevello's (2008) interpersonal goals scale. Items began with the stem: "In my relationship with my partner, I want/try to…" and were rated on a scale ranging from 1 (*not at all*) to 5 (*extremely*). Compassionate goals were measured on an 8-item subscale with items such as: "be supportive of my partner" and "avoid being selfish or self-centered." Self-image goals were measured on a 4-item subscale with items such as: "convince my partner that I am right" and "avoid showing my weaknesses." Scores were derived from averages of items in the subscales used to measure compassionate goals and self-image goals. Both measures demonstrated adequate reliability in the current study (compassionate goals, α = .83; self-image goals, α = .75).

Social desirability was measured using the 13-item Marlowe-Crowne Form C (Reynolds, 1982). Scores represent summed ratings of items reported using a true/false scale (e.g., "I'm always willing to admit it when I make a mistake" and "I have never deliberately said something that hurt someone's feelings"). This scale demonstrated adequate reliability in the current study (α = .68).

Depressive symptoms were measured with the 10-item revised version of the Center for Epidemiological Studies Depression scale (CES-D-10; Radloff, 1977). Participants reported depressive symptoms over the past week (e.g., "I felt depressed" and "I felt that everything I did was an effort") on a scale ranging from 0 (*rarely or none of the time*) to 3 (*most or all of the time*). The scale demonstrated high internal consistency in the current study (α = .83).

Disordered eating symptoms were measured with the 12-item *Eating Disorder Examination Questionnaire - Short* (EDE-QS; Gideon et al., 2016). This scale included

two question formats: 10 questions (e.g., “Have you had a definite fear that you might gain weight?”) began with the stem “On how many of the past 7 days...” and were rated on a scale ranging from 0 (*0 days*) to 3 (*6-7 days*). Two additional questions (e.g., “How dissatisfied have you been with your weight or shape?”) began with the stem “Over the past 7 days...” and were rated on a scale ranging from 0 (*not at all*) to 3 (*markedly*). Items were averaged to form a single composite score for disordered eating symptoms. The scale had adequate reliability in the current study (α = .77).

Attachment was measured using the 12-item *Experiences in Close Relationships–Short Form* (Wei, Russell, Mallinckrodt, & Vogel, 2007). Participants rated 6 items measuring *attachment anxiety* (e.g., “I need a lot of reassurance that I am loved by my partner”) and 6 items measuring *attachment avoidance* (e.g., “I try to avoid getting too close to my partner”) on a scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). Composite measures of *attachment anxiety* and *avoidance* were created by averaging items for each subscale. Both measures had adequate reliability in the current study (anxiety, α = .74; avoidance, α = .79).

Relationship satisfaction was measured using a subscale from the Perceived Relationship Quality Components (PRQC) inventory (Fletcher, Simpson, & Thomas, 2000). This subscale contains 3 items (“How satisfied are you with your relationship?,” “How content are you with your relationship?,” and “How happy are you with your relationship?”) rated on a scale ranging from 1 (*not at all*) to 7 (*extremely*). A composite score was created by averaging these three items. This measure demonstrated excellent reliability in the current study (α = .91).

CHAPTER 3: RESULTS

Overview of Analyses

Data analyses were conducted in two phases. In Phase 1, I focused on the intrapersonal associations linking interpersonal goals to own regulation for a weight management goal. I hypothesized that actors' interpersonal goals predict actors' emotional responses to goal setbacks and progress (Paths A-B) that, in turn, predict actors' intentions to persist (Path C). This part of the model was broken down according to interpersonal goal, such that hypotheses were tested for compassionate goals and then self-image goals, respectively. Primary analyses were followed by analysis of alternative explanations and moderators.

In Phase 2, I focused on the interpersonal associations among study variables to examine the unique contributions of goal-relevant partner support and goal contagion. I hypothesized that partners' compassionate and self-image goals predict partners' partner support (Paths D-E), that, in turn predicts actors' intentions to persist (Path F). Further, I tested an alternative interpersonal pathway, whereby partners' intentions to persist predicts actors' intentions to persist (Path G). Primary analyses were followed by analyses of alternative explanations and moderators.

General analytic strategy. In the current study, individuals are nested within dyads. Because partners are naturally more similar to one another than other members of the broader sample, all analyses must control for nonindependence of the data. Therefore, to adjust for violation of the assumption of independence, I conducted all regression analyses using the MIXED command in SPSS (Kenny et al., 2006). Further, because couple members can be distinguished by their sex, partners are considered

distinguishable. Thus, analyses were conducted using a heterogeneous compound symmetry covariance structure to allow for heterogeneous variances among couple members.

Every person in the dataset had the opportunity to report on their experiences pursuing their own goal and their experiences supporting their partner's goal pursuit. Therefore, for all analyses, data are structured so that each dyad is represented by two lines of data, where each partner within a couple represents both an actor and a partner. Because structural equation modeling generally requires a larger sample (i.e., at least 100 dyads; Kline, 2005), hypotheses were tested using a regression-based path analysis approach. Path models were tested in a series of analyses, with separate regression analyses for each hypothesized path. For each predicted path, I regressed the criterion on the predictor(s), controlling for variables preceding the path in the hypothesized model. Finally, because compassionate and self-image goals were significantly, negatively correlated (pr = -.24, p = .004), all analyses testing for effects of either goal control for the other by entering compassionate and self-image goals simultaneously.

Descriptive statistics, intrapersonal (i.e., within-partner) partial correlations, and interpersonal (i.e., across-partner) partial correlations (Griffin & Gonzalez, 1999) are presented in Table 1. In general, participants were high in compassionate goals and intentions to persist, with more moderate reporting across other primary variables. Participants used the full range of the scale for most variables, with the exception of compassionate goals, partner support, and intentions to persist. Primary variables demonstrated good reliability.

Table 1
Intrapersonal (Within-Partner) and Interpersonal (Cross-Partner) Partial Correlations, Means, Standard Deviations, Ranges, and Reliabilities for Primary Study Variables

	1.	2.	3.	4.	5.	6.	7.	8.
1. Compassionate goals	**.10**	.01	-.10	-.03	-.05	-.14	.08	.01
2. Self-image goals	-.24**	**.17***	.06	-.09	.10	-.09	-.21*	-.01
3. Humble toward progress	.12	.10	**-.02**	-.18*	-.00	-.09	-.12	.06
4. Human toward setbacks	.09	.06	.41***	**-.14**	-.06	-.24**	-.22**	-.00
5. Empowered toward progress	.26**	-.09	.56***	.31***	**-.01**	-.01	.05	.07
6. Ashamed toward setbacks	-.02	.17*	.27***	.08	-.08	**-.04**	.01	-.10
7. Partner support	.31***	-.23**	.19**	.12	.40***	.04	**.41***	.09
8. Intentions to persist	.12	-.22**	.26**	.12	.44***	-.23**	.24**	**.19***
M	4.48	2.47	2.58	3.05	3.27	2.29	3.90	5.26
SD	0.55	0.85	0.87	0.85	1.08	0.89	0.72	1.00
Min-Max	2.13-5	1-4.75	1-5	1-5	1-5	1-5	1.88-5	2-7
Cronbach's α	.83	.75	.66	.75	.92	.88	.85	.85

Note. $N = 142$; *$p < .05$; **$p < .01$, ***$p < .001$. Below the diagonal = partial overall within-partner correlations. Above/on the diagonal = partial overall cross-partner correlations. All coefficients are from partial correlation analyses controlling for sex. Measures range from 1-5 with the exception of intentions to persist, which ranges from 1-7.

The lower diagonal of Table 1 shows the intrapersonal (i.e., within-partner) partial correlations among primary study variables. Consistent with hypotheses, compassionate goals were related to greater partner support. Contrary to expectations, compassionate goals were unrelated to humble responses to progress and human responses to setbacks. Consistent with hypotheses, self-image goals were related to greater ashamed responses to setbacks, less support given, and less intentions to persist. Though, contrary to expectations, self-image goals were unrelated to empowered responses to progress. Finally, intentions to persist were correlated with greater humble responses to progress, less ashamed responses to setbacks, and partner support. Contrary to expectations, intentions to persist were related to greater empowered responses to progress.

The upper diagonal of Table 1 shows the interpersonal (i.e. actor-partner) partial correlations for primary study variables. Actor and partner responses were largely unrelated. Actors' ashamed responses to setbacks and partner support were negatively

related to their partners' human responses to setbacks. Actors' self-image goals were also negatively related to partners' support. Further, actors and partners tended to be moderately correlated in their self-image goals, partner support, and intentions to persist.

Descriptive statistics and intrapersonal (i.e., within-partner) partial correlations for primary study variables with covariates are presented in Tables 2a and 2b. Table 2a displays descriptive statistics and partial correlations for covariates related to individual differences and general relational characteristics. The average for age indicated a sample of mostly young adults with high variability. Social desirability was average among study participants, with a sum at the scale's midpoint. Participants reported generally low levels of depressive symptoms and disordered eating symptoms. Means for attachment anxiety and avoidance were below the scale's midpoint with low variability. Finally, there was a ceiling effect for relationship satisfaction, such that the mean neared the top of the scale.

Table 2a
Means, Standard Deviations, Ranges, and Reliabilities for Covariates and their Intrapersonal (Within-Person) Intraclass Correlations with Primary Study Variables

	Age (yrs)	Social Desirability	Depressive Symptoms	Disordered Eating Symptoms	Attachment Anxiety	Attachment Avoidance	Relationship Satisfaction
1. Compassionate goals	-.12	.10	-.15	-.11	-.03	-.38***	.42***
2. Self-image goals	.02	-.35***	.23**	.13	.22**	.27***	-.34***
3. Humble toward progress	-.05	.10	.01	.07	.07	-.03	.06
4. Human toward setbacks	.25**	.23**	-.19*	.10	.01	-.12	.14
5. Empowered toward progress	-.04	.14	-.14	-.09	-.07	-.26**	.29***
6. Ashamed toward setbacks	-.14	-.09	.37***	.44***	.34***	.22**	-.19*
7. Partner support	-.29**	.08	-.25**	-.09	-.09	-.43***	.50***
8. Intentions to persist	.16	.33***	-.26**	-.22**	-.22**	-.28***	.31***
M	30.99	7.14	0.84	0.87	3.50	2.01	6.39
SD	12.99	2.82	0.52	0.43	1.24	0.90	0.90
Min-Max	18-72	0-13	0-2.2	0-2.25	1-7	1-5	2-7
Cronbach's α	--	.68	.83	.77	.74	.79	.91

Note. $N = 142$; $*p < .05$; $**p < .01$, $***p < .001$. All coefficients are from partial correlation analyses controlling for sex. Variables were measured on the following scales: age (unrestricted), social desirability (0-13), depressive symptoms and disordered eating symptoms (0-3), attachment and satisfaction (1-7).

Moving on to the partial correlations in Table 2a, age was positively related to human responses to setbacks and negatively related to partner support. Social desirability was associated with greater self-image goals, less human responses to progress, and less intentions to persist in the expected directions. Depressive symptoms were positively related to self-image goals and ashamed responses to setbacks, and negatively related to human responses to setbacks, support toward partner, and intentions to persist. Disordered eating symptoms were associated with greater ashamed responses to setbacks and less intentions to persist. Attachment anxiety positively related to self-image goals and ashamed responses to setbacks, and negatively related to intentions to persist. Attachment avoidance was negatively related to compassionate goals, empowered responses to progress, support for partner, and intentions to persist. Further, attachment avoidance was positively related to self-image goals and ashamed responses to setbacks. Finally, relationship satisfaction positively related to compassionate goals, empowered responses to progress, partner support, and intentions to persist. It was negatively related to self-image goals and ashamed responses to setbacks.

Table 2b displays descriptive statistics and partial correlations for covariates related to the weight management goal. The mean for BMI was situated at the lower end of the NIH's category for overweight, with deviations entering into the normal weight category at the lower end and the obese I category at the upper end. Goal history had an average that was higher than the scale midpoint and a standard deviation that revealed high variability within the sample. Averages for goal importance, progress, and setback amount were at the midpoint, whereas awareness and value of partner's goals had higher

averages. All five variables were measured on a 5-point scale and demonstrated adequate variance.

Table 2b
Means, Standard Deviations, Ranges, and Reliabilities for Covariates and their Intrapersonal (Within-Person) Intraclass Correlations with Primary Study Variables

	BMI	Goal History	Goal Importance	Progress Amount	Setbacks Amount	Awareness of Partner's Goal	Value of Partner's Goal
1. Compassionate goals	-.06	-.08	-.06	.17*	-.15	.13	.15
2. Self-image goals	.03	.02	-.05	-.08	.24**	-.11	-.12
3. Humble toward progress	-.08	.14	.32***	.29***	-.07	.01	.12
4. Human toward setbacks	-.03	.09	.25**	.09	.06	-.08	.08
5. Empowered toward progress	-.25**	.02	.39***	.65***	-.37***	.08	.22**
6. Ashamed toward setbacks	.15	.02	-.01	-.18*	.44***	-.09	-.14
7. Partner support	-.28***	-.04	.16	.34***	-.08	.44***	.48***
8. Intentions to persist	-.05	.08	.38***	.35***	-.41***	.05	.15
M	26.18	4.41	3.79	2.79	2.86	3.70	4.30
SD	3.76	1.54	.91	1.18	0.93	1.09	.87
Min-Max	19.48-43.85	1-7	1-5	1-5	1-5	1-5	1-5
Cronbach's α	--	--	--	--	--	.92	--

Note. $N = 142$; *$p < .05$; **$p < .01$, ***$p < .001$. All coefficients are from partial correlation analyses controlling for sex. Measures range from 1-5 with the exception of BMI, which ranges from 18.50 to 35 in the current study.

Of note, BMI was related to less empowered responses to progress and less partner support. Goal history was unrelated to primary study variables. Goal importance was related to greater humble responses to progress, human responses to setbacks, empowered responses to progress, and intentions to persist. Those who reported greater progress in the past month also reported greater compassionate goals, humble responses to progress, empowered responses to progress, partner support, and intentions to persist. Setbacks were associated with greater self-image goals, less empowered responses to progress, greater ashamed responses to setbacks, and less intentions to persist. Further, awareness and value of partner's goal and were related to greater partner support.

Intrapersonal Processes: Actors' Compassionate and Self-Image Goals Predict Actors' Regulation of Weight Management Goals

Phase 1 analyses examined a path model in which actors' compassionate and self-image goals predict actors' emotional responses to progress (*humble, empowered*) and setbacks (*human, ashamed*), which in turn predict actors' intentions to persist (see Figure 2). In Phase 1, hypotheses are tested using actor variables. Though, because data are structured so that all participants can be actors and partners, analyses test the same intrapersonal predictions for partners.

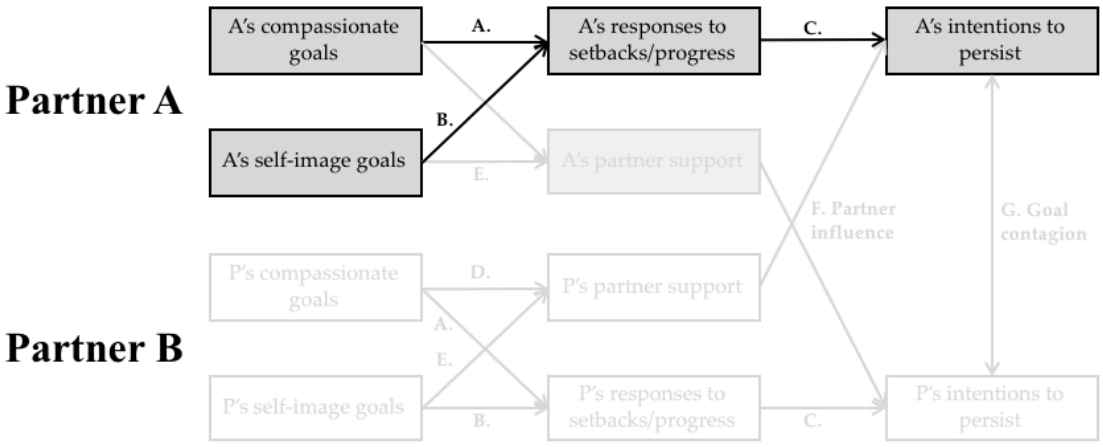

Figure 2. Conceptual model of Phase 1 analyses testing intrapersonal pathways linking compassionate and self-image goals to intentions to persist.

Actor's Goals and Their Own Emotional Responses to Progress and Setbacks

First, I examined whether actors' compassionate goals predict actors' greater *humble* responses to progress and *human* responses to setbacks (Path A). Second, I examined whether actors' self-image goals predict actors' greater *empowered* responses to progress and *ashamed* responses to setbacks (Path B). Hypotheses were tested one at a time, with compassionate and self-image goals entered simultaneously to predict each of

the four emotional responses because of their moderate correlation. Importantly, due to high correlations among emotions measured in the same scale (responses to progress: *pr* = .56, $p < .001$); responses to setbacks: *pr* = .08, *p* = .38), analyses control for the other possible emotion measured in response to setbacks or progress, respectively (e.g., the model predicting humble responses to progress controls for empowered responses to progress and vice versa).

First, I examined associations between compassionate goals and emotional responses to progress and setbacks (Path A). Table 3 presents the standardized regression coefficients for the associations between compassionate goals and emotional responses to progress and setbacks (also shown in Figure 3). When I regressed humble responses to progress on compassionate goals controlling for self-image goals and empowered responses to progress, compassionate goals were unrelated to humble responses to progress. When I regressed human responses to setbacks on compassionate goals controlling for self-image goals and ashamed responses to setbacks, compassionate goals were unrelated to human responses to setbacks. Thus, compassionate goals were not directly associated with humble responses to progress or human responses to setbacks.

Table 3
Standardized Regression Coefficients for the Associations Among Interpersonal Goals and Emotional Responses to Progress and Setbacks

	β	*t*(df)	*p*	95% CI
DV: Humble toward progress				
Compassionate goals	.01	.10(126.06)	.92	[-.12, .13]
Self-image goals	.13	2.02(130.34)	.05	[.00, .25]
Empowered toward progress	.49	7.90(133.84)	.000	[.37, .62]
DV: Human toward setbacks				
Compassionate goals	.08	1.15(128.18)	.25	[-.06, .23]
Self-image goals	.06	.83(123.75)	.41	[-.08, .21]
Ashamed toward setbacks	.03	.43(135.96)	.67	[-.11, .17]

DV: Empowered toward progress				
Self-image goals	-.10	-1.36(130.58)	.18	[-.25, .05]
Compassionate goals	.18	2.39(133.57)	.02	[.03, .34]
Humble toward progress	.59	7.94(133.65)	.000	[.44, .74]
DV: Ashamed toward setbacks				
Self-image goals	.15	1.87(130.56)	.06	[-.01, .30]
Compassionate goals	.02	.22 (132.11)	.83	[-.14, .17]
Human toward setbacks	.05	.71(133.33)	.67	[-.10, .20]

Note. N = 142. All predictors were standardized prior to analyses. Each analysis controls for the other interpersonal goal as well as the other possible emotional response to progress or setbacks, respectively. Analyses were conducted using actor variables.

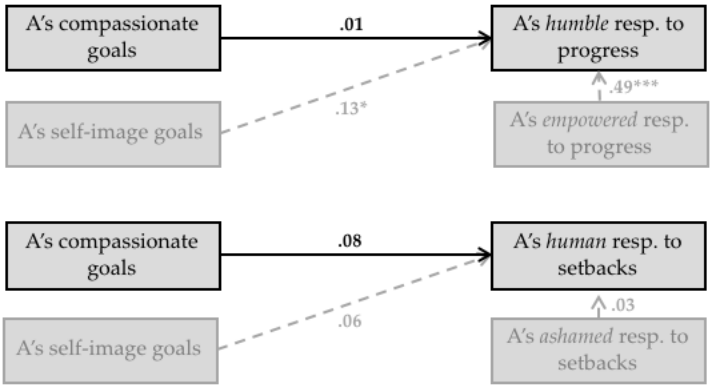

Figure 3. Path analyses of the effects of compassionate goals on emotional responses to progress and setbacks. Analyses controls for the other interpersonal goal as well as the other possible emotional response to progress or setbacks, respectively.

I next tested whether characteristics of the self (social desirability, depressive symptoms, disordered eating symptoms), the goal (goal importance, setback amount, progress amount), or the relationship (attachment, satisfaction) altered associations between compassionate goals and emotional responses to progress and setbacks. Table 4 displays the standardized regression coefficients for compassionate goals when primary analyses were rerun, including each covariate separately. Results did not change when controlling for any of these variables--compassionate goals remained unrelated to humble

responses to progress and human responses to setbacks. Thus, this set of individual, goal, and relationship factors did not affect study findings.

Table 4
Assessing Covariates for the Influence of Interpersonal Goals on Emotional Responses to Progress and Setbacks

	Compassionate Goals			Self-Image Goals			Covariate		
	β	95% CI	*p*	β	95% CI	*p*	β	95% CI	*p*
DV: Humble toward Progress	.01	[-.12, .13]	.92	.13	[.00, .25]	.05			
Social Desirability	.01	[-.12, .13]	.91	.16	[.03, .29]	.02	.08	[-.05, .20]	.25
Depressive Symptoms	.00	[-.12, .13]	.98	.11	[-.01, .24]	.08	.05	[-.07, .17]	.43
Disordered Eating Symptoms	.02	[-.11, .14]	.79	.12	[-.00, .24]	.06	.09	[-.03, .21]	.14
Goal Importance	.02	[-.10, .15]	.70	.13	[.01, .25]	.04	.12	[-.01, .25]	.08
Progress Amount	.01	[-.12, .13]	.91	.13	[.00, .25]	.05	-.11	[-.26, .04]	.16
Setback Amount	.01	[-.12, .14]	.88	.10	[-.02, .23]	.10	.11	[-.02, .24]	.08
Attachment	.02	[-.11, .15]	.80	.10	[-.03, .22]	.13	.06, .07	[-.06, .19] [-.07, .20]	.32, .31
Satisfaction	.03	[-.11, .16]	.69	.10	[-.02, .23]	.11	-.08	[-.22, .06]	.25
DV: Human toward Setbacks	.08	[-.06, .23]	.25	.06	[-.08, .21]	.41			
Social Desirability	.09	[-.05, .23]	.21	.16	[.01, .30]	.04	.27	[.13, .41]	.000
Depressive Symptoms	.05	[-.09, .20]	.46	.09	[-.06, .23]	.23	-.20	[-.35, -.05]	.01
Disordered Eating Symptoms	.09	[-.06, .24]	.23	.06	[-.09, .21]	.42	.07	[-.09, .23]	.39
Goal Importance	.10	[-.04, .24]	.16	.08	[-.07, .22]	.29	.21	[.07, .35]	.003
Progress Amount	.07	[-.07, .22]	.33	.06	[-.09, .21]	.41	.08	[-.06, .23]	.25
Setback Amount	.09	[-.06, .23]	.25	.06	[-.09, .21]	.42	.01	[-.15, .17]	.88
Attachment	.04	[-.12, .19]	.65	.08	[-.07, .23]	.31	.00, -.11	[-.15, .16] [-.27, .05]	.98, .17
Satisfaction	.03	[-.12, .19]	.69	.10	[-.05, .25]	.20	.16	[-.00, .32]	.05
DV: Empowered toward Progress	.18	[.03, .34]	.02	-.10	[-.25, .05]	.18			
Social Desirability	.19	[.03, .34]	.02	-.10	[-.26, .07]	.24	.03	[-.13, .19]	.68
Depressive Symptoms	.17	[.02, .33]	.03	-.09	[-.24, .07]	.27	-.11	[-.26, .04]	.16
Disordered Eating Symptoms	.17	[.01, .32]	.03	-.10	[-.25, .05]	.21	-.09	[-.24, .06]	.23
Goal Importance	.21	[.07, .36]	.01	-.08	[-.22, .07]	.30	.27	[.12, .42]	.001
Progress Amount	.13	[.01, .25]	.04	-.06	[-.18, .06]	.35	.53	[.41, .65]	.000
Setback Amount	.16	[.01, .30]	.03	-.04	[-.18, .11]	.61	-32	[-.46, -.18]	.000
Attachment	.12	[-.04, .28]	.14	-.07	[-.22, .09]	.38	-.05, -.19	[-.20, .10] [-.36, -.03]	.52, .02
Satisfaction	.11	[-.05, .27]	.18	-.05	[-.20, .11]	.54	.21	[.05, .37]	.01
DV: Ashamed toward Setbacks	.02	[-.14, .17]	.83	.15	[-.01, .35]	.06			
Social Desirability	.01	[-.14, .17]	.87	.14	[-.03, .31]	.10	-.05	[-.21, .12]	.56
Depressive Symptoms	.01	[-.13, .15]	.83	.07	[-.07, .21]	.33	.33	[.19, .47]	.000

Disordered Eating Symptoms	.06	[-.08, .20]	.39	.12	[-.02, .26]	.09	.37	[.24, .51]	.000
Goal Importance	.02	[-.14, .17]	.83	.14	[-.01, .30]	.07	-.01	[-.16, .14]	.90
Progress Amount	.05	[-.11, .20]	.54	.14	[-.01, .30]	.06	-.17	[-.32, -.03]	.02
Setback Amount	.05	[-.09, .19]	.46	.07	[-.08, .21]	.36	.39	[.25, .52]	.000
Attachment	.02	[-.12, .17]	.75	.06	[-.08, .21]	.40	.25, .12	[.11, .39] [-.03, .28]	.001, .12
Satisfaction	.08	[-.09, .24]	.35	.09	[-.06, .25]	.24	-.18	[-.35, -.01]	.04

Note. $N = 142$; The first row in each set of analyses shows the initial coefficients for Paths A and B. Path A and B analyses (regressing both interpersonal goals and the other possible emotional response to progress or setbacks, respectively on the focal emotional response) were reanalyzed, controlling for each covariate separately. All predictors were standardized prior to analyses and analyses were conducted using actor variables.

Second, I examined associations between self-image goals and emotional responses to progress and setbacks (Path B). Table 3 presents the standardized regression coefficients for the associations between self-image goals and emotional responses to progress and setbacks (also shown in Figure 4). When I regressed empowered responses to progress on self-image goals controlling for compassionate goals and humble responses to progress, self-image goals were unrelated to empowered responses to progress. When I regressed ashamed responses to setbacks on self-image goals controlling for compassionate goals and human responses to setbacks, self-image goals were related to marginally greater ashamed responses. Thus, self-image goals were not associated with empowered responses to progress, however, were marginally related to ashamed responses to setbacks.

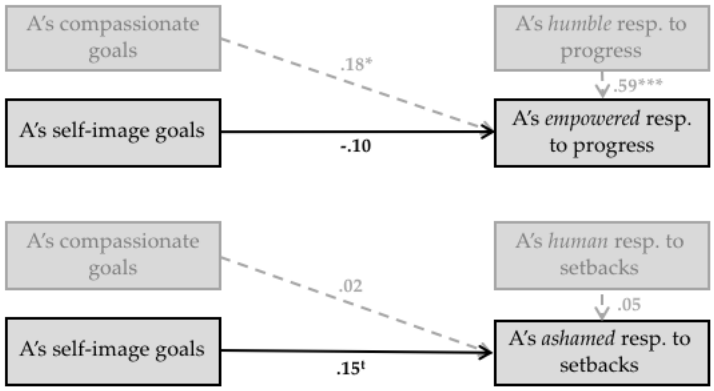

Figure 4. Path analyses of the effects of self-image goals on emotional responses to progress and setbacks. Analyses controls for the other interpersonal goal as well as the other possible emotional response to progress or setbacks, respectively.

Again, I tested whether characteristics of the self (social desirability, depressive symptoms, disordered eating symptoms), the goal (goal importance, setback amount, progress amount), or the relationship (attachment, satisfaction) altered associations between self-image goals and emotional responses to progress and setbacks. I reanalyzed each pathway, including the abovementioned covariates one at a time. Table 4 presents the standardized regression coefficients for self-image goals when I reran primary analyses, controlling for each covariate. Self-image goals and empowered responses to progress remained unrelated when controlling for each variable. Depressive symptoms, setback amount, attachment anxiety, and relationship satisfaction weakened the magnitude of the association between self-image goals and ashamed responses to setbacks. Thus, these variables accounted for the marginal link between self-image goals and ashamed responses to setbacks.

Actors' Emotional Responses to Progress and Setbacks and Intentions to Persist

Next, I examined the implications of emotional responses to progress and

setbacks for intentions to persist. I hypothesized feeling *humble* in response to goal progress and *human* in response to setbacks would relate to greater intentions to persist, whereas feeling *empowered* in response to progress and *ashamed* in response to goal setbacks would relate to less intentions to persist (Path C). Because emotional responses were correlated (see Table 1), all four emotional responses were entered simultaneously in a regression analysis to predict intentions to persist controlling for preceding variables in the model (i.e., actors' interpersonal goals).

Table 5 displays the standardized regression coefficients for the associations between emotional responses to progress and setbacks and intentions to persist (also shown in Figure 5). Human responses to setbacks and humble responses to progress were unrelated to intentions to persist whereas empowered responses to progress and ashamed responses to setbacks were significantly related to intentions to persist. Thus, only one of my hypotheses was supported at this stage: ashamed responses to setbacks were negatively associated with intentions to persist. Contrary to Path C hypotheses, empowered responses to progress were positively related to intentions to persist and humble and human responses were unrelated to intentions to persist.

Table 5
Standardized Regression Coefficients for the Associations Among Emotional Responses to Progress and Setbacks and Intentions to Persist

DV: Intentions to Persist	β	*t*(df)	*p*	95% CI
Humble toward progress	.12	1.19(126.32)	.24	[-.08, .32]
Human toward setbacks	.05	.59(121.85)	.55	[-.11, .21]
Empowered toward progress	.31	3.15(126.58)	.002	[.11, .50]
Ashamed toward setbacks	-.25	-2.97(127.98)	.004	[-.41, -.08]
Compassionate Goals	-.00	-.05(128.82)	.96	[-.16, .16]
Self-Image Goals	-.16	-2.07(118.02)	.04	[-.32, -.01]

Note. $N = 142$. Standardized predictors were entered simultaneously to predict intentions to persist. Analyses were conducted using actor variables.

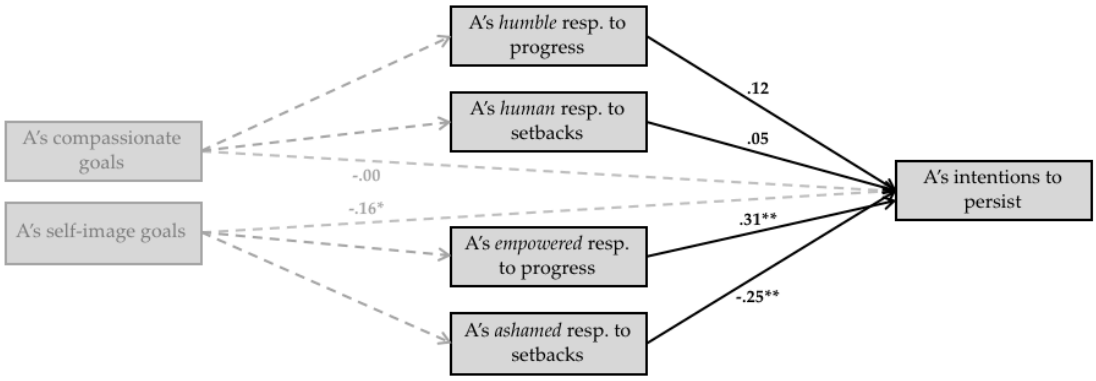

Figure 5. Path analyses of the effects of emotional responses to progress and setbacks on intentions to persist.

Next, I tested whether characteristics of the self (social desirability, depressive symptoms, disordered eating symptoms), the goal (goal importance, setback amount, progress amount), or the relationship (attachment, satisfaction) altered associations between emotional responses to progress and setbacks and intentions to persist. Table 6 presents the standardized regression coefficients for emotional responses to setbacks and progress when I reran primary analyses including each covariate separately. Results remained largely unchanged—the associations between humble responses to progress and human responses to setbacks and intentions to persist remained nonsignificant. The association between empowered responses to progress and intentions to persist became marginal when controlling for progress amount. Further, the association between ashamed responses to setbacks and intentions to persist became marginal with the addition of disordered eating symptoms and nonsignificant with the addition of setback amount. Thus, individuals' reported disordered eating symptoms, progress, and setbacks altered the effects of egosystem emotions on intentions to persist.

Table 6

Assessing Covariates for the Associations between Emotional Responses to Progress and Setbacks and Intentions to Persist

	Humble toward Progress			Human toward Setbacks			Empowered toward Progress			Ashamed toward Setbacks			Covariate		
	B	95% CI	p	β	95% CI	p	β	95% CI	p	β	95% CI	p	β	95% CI	p
DV: Intentions to Persist	.10	[-.10, .30]	.33	.03	[-.13, .20]	.68	.33	[.15, .52]	.001	-.26	[-.42, -.10]	.002			
Social Desirability	.12	[-.07, .32]	.21	-.03	[-.19, .14]	.75	.31	[.12, .50]	.001	-.22	[-.38, -.06]	.01	.25	[.08, .41]	.003
Depressive Symptoms	.12	[-.07, .32]	.22	-.00	[-.16, .16]	.97	.29	[.10, .48]	.003	-.24	[-.41, -.06]	.01	-.13	[-.30, .03]	.11
Disordered Eating Symptoms	.09	[-.10, .29]	.35	.02	[-.13, .18]	.77	.33	[.14, .51]	.001	-.17	[-.34, .01]	.06	-.10	[-.26, .06]	.22
Goal Importance	.10	[-.10, .29]	.33	.02	[-.14, .17]	.83	.23	[.03, .42]	.02	-.23	[-.39, -.07]	.01	.23	[.07, .40]	.01
Progress Amount	.12	[-.08, .32]	.23	.06	[-.10, .22]	.48	.22	[-.01, .45]	.06	-.22	[-.39, -.06]	.01	.13	[-.06, .33]	.17
Setback Amount	.10	[-.09, .29]	.31	.09	[-.07, .25]	.26	.22	[.02, .41]	.03	-.14	[-.31, .04]	.12	-.28	[-.45, -.10]	.002
Attachment	.14	[-.06, .34]	.17	.01	[-.15, .17]	.88	.27	[.08, .46]	.01	-.24	[-.41, -.06]	.01	-.12, -.12	[-.27, .04] [-.29, .04]	.15, .15
Satisfaction	.13	[-.07, .33]	.21	.02	[-.14, .18]	.79	.28	[.09, .47]	.01	-.22	[-.39, -.06]	.01	.17	[-.01, .35]	.06

Note. $N = 142$; *$p < .05$; **$p < .01$, ***$p < .001$. The first row displays initial Path C coefficients. Path C analyses (regressing all four emotional responses and the interpersonal goals on intentions to persist) were reanalyzed, controlling for each covariate separately. All predictors were standardized prior to analyses and analyses were conducted using actor variables.

Do these associations differ by age, sex, BMI, goal type, goal history, or progress/setback amount?

It is possible that the hypothesized intrapersonal pathways are moderated by characteristics of the self (i.e., age, sex, BMI) or goal (i.e., goal type, goal history, progress/setback amount). Primary analyses were reanalyzed twice for each moderator when predicting emotional responses to progress and setbacks: once with the addition of the moderator and interaction term with compassionate goals and once with the addition of the moderator and interaction term with self-image goals. The same procedure was followed when reanalyzing primary analyses predicting intentions to persist: analyses were replicated with the inclusion of the interaction terms between moderators and each of the four emotional responses.

First, I explored the moderating role of characteristics of the self. Sex and BMI did not moderate any of the eight predicted pathways. Age moderated two of the eight predicted pathways. Age interacted with human responses to setbacks to predict intentions to persist, such that human responses led to greater intentions for younger participants ($\beta = .23$, $p = .05$), but lower intentions for older participants ($\beta = -.24$, $p = .04$). Age also interacted with humble responses to progress to predict intentions to persist, such humble responses led to greater intentions to persist for younger participants ($\beta = .33$, $p = .02$) but not for older participants ($\beta = .02$, $p = .84$). Although sex and BMI were not significant moderators of the intrapersonal pathways, age moderated pathways for human responses to setbacks and humble responses to progress and intentions to persist.

Next, I tested characteristics of the goal as potential moderators. Goal type did not significantly moderate any of the eight pathways tested. Goal history interacted with humble responses to progress to predict intentions to persist, such that humble responses to progress predicted greater intentions to persist for those with a shorter goal history (β = .28, p = .03), but not for those with longer goal histories (β = .00, p = .97). Thus, when weight management goal efforts were relatively new, humble responses to progress led to greater intentions to persist. Progress amount interacted with self-image goals to predict empowered responses to progress, such that self-image goals predicted less empowered responses to progress when participants reported less progress (β = -.21, p = .01), but not when they reported greater progress (β = -.11, p = .20). Thus, with less goal progress, self-image goals were negatively related to empowered responses to progress. Progress amount also interacted with humble responses to progress to predict intentions to persist, such that humble responses to progress predicted greater intentions to persist for participants reporting greater (β = .22, p = .04) but not less progress (β = -.12, p = .42). Thus, with greater goal progress, humble responses to progress were positively associated with intentions to persist. Setback amount interacted with ashamed responses to setbacks to predict intentions to persist, such that ashamed responses to setbacks predicted lower intentions to persist when participants reported fewer (β = -.34, p = .004), but not more setbacks (β = .03, p = .81). Thus, with fewer goal setbacks, ashamed responses to setbacks were negatively related to intentions to persist.

Summary of intrapersonal processes. Overall, there was inconsistent evidence for hypotheses that interpersonal goals predict emotional responses to progress and setbacks, which lead to intentions to persist. Compassionate goals were not associated

with humble responses to progress or human responses to setbacks. Self-image goals were unrelated to empowered responses to progress. However, moderation analyses showed that with less goal progress, self-image goals were related to lower empowered responses to progress. Self-image goals were marginally associated with ashamed responses to setbacks, though, setback amount, depressive symptoms, attachment anxiety, and relationship satisfaction accounted for this association.

Initial analyses suggested that, contrary to my hypotheses, humble responses to progress and human responses to setbacks were unrelated to intentions to persist. Though, positive associations between humble responses to progress, human responses to setbacks, and intentions to persist emerged upon examination of moderators. Specifically, age moderated both pathways, such that humble responses to progress and human responses to setbacks led to greater intentions to persist for younger participants. For older participants, humble responses to progress were unrelated to intentions to persist and human responses to setbacks led to lower intentions to persist. Further, when goal efforts were relatively new and when goal progress was greater, humble responses to progress were positively related to intentions to persist.

Both empowered responses to progress and ashamed responses to setbacks were associated with intentions to persist. Contrary to my hypothesis, empowered responses to progress were positively related to intentions to persist. Though, this association was explained by progress amount. In support of my hypothesis, ashamed responses to setbacks were negatively related to intentions to persist, however, the association was explained by disordered eating symptoms and setback amount. Again, moderation analyses provided some clarification for findings. With fewer setbacks, ashamed

responses to setbacks were negatively related to intentions to persist. Thus, although empowered and ashamed responses seemed to predict intentions to persist, disordered eating symptoms and amount of progress and setbacks explained these associations.

Interpersonal Processes: Partners' Compassionate and Self-Image Goals Predict Actors' Regulation of Weight Management Goals

In Phase 2, I examined a path model in which partners' interpersonal goals simultaneously predict their goal-relevant partner support that, in turn, predicts actors' intentions to persist (see Figure 6). I also examined a competing pathway in which partners' intentions to persist leads to actors' intentions to persist. Phase 2 analyses use both actor and partner variables in an examination of partner effects. All predictors were standardized for ease of interpretation across measurement scales.

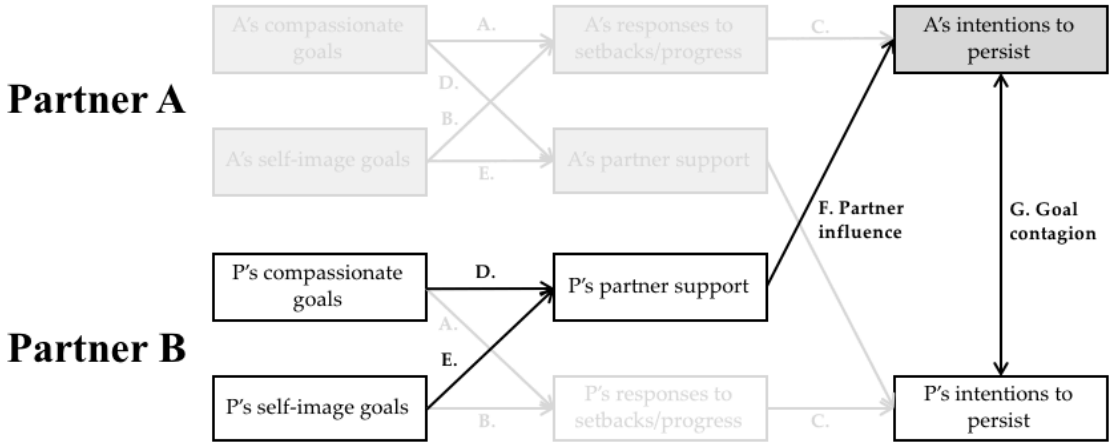

Figure 6. Conceptual model of Phase 2 analyses testing interpersonal pathways linking partners' compassionate and self-image goals to actors' intentions to persist

Partners' Interpersonal Goals and Their Use of Goal-Relevant Partner Support

I hypothesized partners' compassionate goals would positively relate to their provision of goal-relevant partner support (Path D), whereas partners' self-image goals

would negatively relate to partner's provision of goal-relevant support (Path E). This set of hypotheses was tested by regressing partners' reported partner support on their compassionate and self-image goals simultaneously. Figure 7 displays the standardized regression coefficients for compassionate and self-image goals predicting partner support. As expected, compassionate goals were positively related to goal-relevant partner support, β = .18, *t* (125.67) = 3.31, *p* = .001 [95% CI = .07, .30]. Contrary to my hypothesis, self-image goals were unrelated to partner support, β = -.08, *t* (133.31) = -1.36, *p* = .18 [95% CI = -.19, .04].

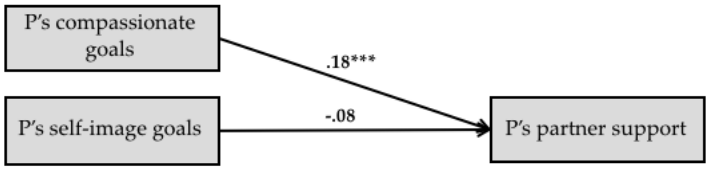

Figure 7. Path analyses of the effects of partners' compassionate and self-image goals on partners' support.

Next, I examined whether characteristics of the self (social desirability, depressive symptoms), goal (awareness of partner's goal, value of partner's goal), or relationship (attachment, relationship satisfaction) affected links between partners' interpersonal goals and their provision of goal-relevant partner support. I reanalyzed the association between partners' interpersonal goals and partner support, controlling for each covariate in separate analyses. Table 7 shows the standardized regression coefficients for compassionate and self-image goals with each covariate included in the model. The association between self-image goals and partner support remained nonsignificant. The link between compassionate goals and partner support became nonsignificant when attachment avoidance and relationship satisfaction were included as covariates (βs = .09-

.10, *p*s = .09). Thus, attachment avoidance and relationship satisfaction appear to account for the association between compassionate goals and goal-relevant partner support.

Table 7
Assessing Covariates for the Associations between Partners' Interpersonal Goals and Partner Support

	P's Compassionate Goals			P's Self-Image Goals			Covariate		
	β	95% CI	*p*	β	95% CI	*p*	β	95% CI	*p*
DV: P's Partner Support	.18	[.07, .30]	.001	-.08	[-.19, .04]	.18			
P's Social Desirability	.18	[.07, .29]	.002	-.07	[-.19, .05]	.24	.01	[-.11, .13]	.88
P's Depressive Symptoms	.16	[.05, .27]	.004	-.06	[-.17, .05]	.29	-.14	[-.25, -.03]	.02
P's Awareness of Partner's Goal	.16	[.05, .27]	.003	-.09	[-.19, .02]	.11	.24	[14, .35]	.000
P's Value of Partner's Goal	.14	[.05, .24]	.004	-.06	[-.16, .04]	.27	.30	[.21, .40]	.000
P's Attachment	.09	[-.02, .20]	.09	-.05	[-.16, .06]	.41	.02, -.23	[-.08, .12], [-.34, -.12]	.71, .000
P's Satisfaction	.10	[-.02, .21]	.09	-.02	[-.13, .09]	.71	.29	[.17, .41]	.000

Note. $N = 142$. The first row displays initial coefficients for Paths D and E. Analyses for Paths D and E (regressing partners' compassionate and self-image goals on their provision of partner support) were reanalyzed, controlling for each covariate separately (with the exception of attachment, which included attachment avoidance and anxiety in the same analysis). All predictors were standardized prior to analyses and analyses were conducted using only partner variables.

Partners' Support and Intentions to Persist and Actors' Intentions to Persist

After examining the influence of partners' interpersonal goals on their partner support, I assessed two sources of partner influence upon actors' intentions to persist. First, I hypothesized partners' support would relate to actors' greater intentions to persist (Path F). Second, I tested a secondary interpersonal pathway where partners' intentions to persist would relate to actors' intentions to persist (Path G). These hypotheses were tested in a single regression analysis with partners' support, partners' intentions to persist, preceding partner variables (i.e., partners' interpersonal goals), and preceding actor variables (i.e., actors' interpersonal goals and emotional responses to setbacks and progress) entered simultaneously to predict actors' intentions to persist. Table 8 shows the standardized regression coefficients for the associations between partners' support and intentions to persist and actors' intentions to persist controlling for preceding actor

and partner variables (also shown in Figure 8). Hypotheses were unsupported: the associations between partners' support and actors' intentions to persist (Path F) and between partners' intentions to persist and actors' intentions to persist (Path G) were nonsignificant.

Table 8
Standardized Regression Coefficients for the Associations Among Partners' Goal-Relevant Partner Support and Goal Contagion and Actors' Intentions to Persist

DV: A's Intentions to Persist	β	*t*(df)	*p*	95% CI
P's Partner Support	.04	.47(123.01)	.64	[-.13, .20]
P's Intentions to Persist	.12	1.52(122.97)	.13	[-.04, .28]
P's Compassionate Goals	-.05	-.57(115.28)	.57	[-.20, .11]
P's Self-Image Goals	-.01	-.18(128.00)	.86	[-.17, .14]
A's Compassionate Goals	.01	.07(126.73)	.94	[-.15, .16]
A's Self-Image Goals	-.15	-1.93(123.06)	.06	[-.31, .00]
A's Humble toward Progress	.10	.95(127.30)	.34	[-.10, .29]
A's Human toward Setbacks	.01	.13(126.18)	.90	[-.15, .17]
A's Empowered toward Progress	.32	3.41(127.48)	.001	[.14, .52]
A's Ashamed toward Setbacks	-.23	-2.81(127.75)	.01	[-.40, -.07]

Note. $N = 142$. Standardized predictors were entered simultaneously to predict actors' intentions to persist. Analyses were conducted using both actor and partner variables.

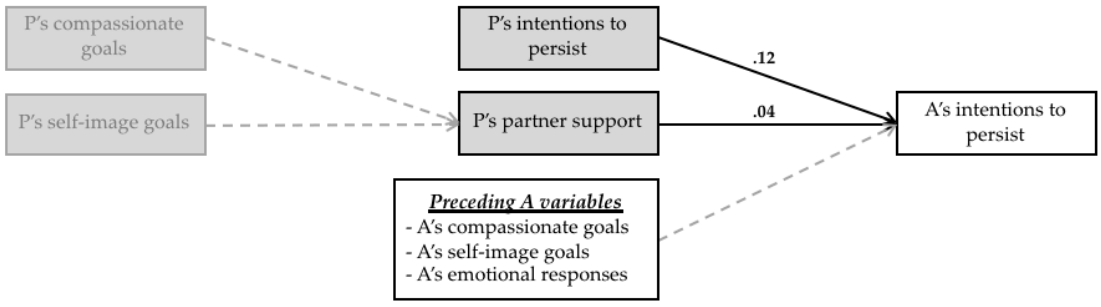

Figure 8. Path analyses of the effects of partners' support and intentions to persist on actors' intentions to persist.

Analyses thus far revealed nonsignificant associations between partners' goal-relevant partner support and actors' intentions to persist and partners' intentions to persist and actors' intentions to persist. Next, I examined whether characteristics of the self

(social desirability, depressive symptoms), goal (awareness of partner's goal, value of partner's goal), or relationship (attachment, relationship satisfaction) affected these links. Table 9 shows the standardized regression coefficients for primary analyses with the addition of each covariate entered in separate analyses. Results were unchanged for the nonsignificant associations between partners' support and actors' intentions to persist and partners' intentions to persist and actors' intentions to persist.

Table 9
Assessing Covariates for the Associations between Partners' Support and Intentions to Persist and Actors' Intentions to Persist

	P's Partner Support			P's Intentions to Persist			Covariate		
	β	95% CI	*p*	β	95% CI	*p*	β	95% CI	*p*
DV: A's Intentions to Persist	.04	[-.13, .20]	.64	.12	[-.04, .28]	.13			
P's Social Desirability	.04	[-.12, .21]	.60	.09	[-.07, .26]	.26	.10	[-.06, .29]	.20
P's Depressive Symptoms	.03	[-.14, .20]	.72	.11	[-.05, .27]	.19	-.02	[-.18, .14]	.80
P's Awareness of Partner's Goal	.01	[-.17, .19]	.90	.13	[-.03, .28]	.12	.06	[-.11, .23]	.50
P's Value of Partner's Goal	-.04	[-.22, .15]	.70	.12	[-.04, .27]	.14	.14	[-.03, .30]	.10
P's Attachment	.06	[-.12, .23]	.54	.10	[-.06, .26]	.21	-.10, .06	[-.26, .06], [-.12, .24]	.21, .51
P's Satisfaction	.04	[-.13, .22]	.63	.12	[-.04, .28]	.13	-.01	[-.20, .17]	.88

Note. $N = 142$. The first row displays initial coefficients for Paths F and G. Analyses for Paths F and G (regressing partners' support, partners' intentions to persist, partners' interpersonal goals, actors' interpersonal goals, and actors' emotional responses to setbacks and progress on actors' intentions to persist) were reanalyzed, controlling for each covariate separately (with the exception of attachment, which included attachment avoidance and anxiety in the same analysis). All predictors were standardized prior to analyses and analyses were conducted using both actor and partner variables.

Do these associations differ by actor's or partner's sex, age, BMI, goal type, or goal history?

It was possible that the associations between partners' interpersonal goals and their goal-relevant partner support differ based on characteristics of the partner (i.e., P's sex, age, BMI) or the actor (i.e., A's sex, age, BMI, goal type, goal history). These factors may also moderate the hypothesized pathways between partners' support and actors' intentions to persist and partners' intentions to persist and actors' intentions to persist.

Primary analyses were reanalyzed twice for each moderator when predicting partner support: once with the addition of the moderator and interaction term with compassionate goals and once with the addition of the moderator and interaction term with self-image goals. The same procedure was followed when reanalyzing primary analyses predicting actors' intentions to persist: once with the addition of the moderator and interaction with partners' partner support and once with the addition of the moderator and interaction with partners' intentions to persist.

First, I assessed the possibility that these associations differ by sex and age. Sex did not significantly moderate any of the four pathways tested. Age moderated the association between partners' support and actors' intentions to persist, such that partners' provision of support led to actors' intentions to persist for older participants (actor's age: $\beta = .22$, $p = .04$; partner's age: $\beta = .21$, $p = .04$), but not for younger participants (actor's age: $\beta = -.11$, $p = .34$; partner's age: $\beta = -.13$, $p = .25$). Thus, for older couples, partners' support was positively associated with individuals' intentions to persist. Next, I examined whether characteristics of the partner moderated these associations. Partners' BMI significantly moderated the association between partners' self-image goals and partner support, such that self-image goals predicted less partner support when participants reported a lower BMI ($\beta = -.20$, $p = .01$), but not when they reported a higher BMI ($\beta = .03$, $p = .69$). Thus, for support providers with a lower BMI, their self-image goals led to less partner support.

It was also possible that characteristics of the actor moderate the interpersonal pathways. Actors' goal type did not moderate any of the four hypothesized pathways. Actors' BMI significantly moderated the association between partners' self-image goals

and their provision of partner support, such that partners' self-image goals predicted lower partner support for actors at a lower BMI (β = -.19, *p* = .02), but not for actors at a higher BMI (β = .04, *p* = .57). Thus, for support recipients with a lower BMI, support providers' self-image goals led to less support. Actors' goal history interacted with partners' support to predict actors' intentions to persist, such that partners' support predicted actors' greater intentions to persist for those with a longer goal history (β = .21, *p* = .04), but not for those with shorter goal histories (β = -.21, *p* = .08). Thus, when individuals reported more prior attempts at weight management, partners' support was positively related to individuals' intentions to persist

Summary of interpersonal processes. Partners' compassionate goals were associated with use of positive goal-relevant partner support strategies in response to actors' weight management goals. Though, attachment avoidance and relationship satisfaction appear to explain why compassionate goals lead to partner support. Initially, partners' self-image goals were unrelated to partner support, however, when actors or partners had a lower BMI, partners' self-image goals were negatively related to partner support.

I also examined two potential pathways through which partners may influence actors' intentions to persist. Partners' support did not impact actors' intentions to persist, however, evidence of moderation was found. Both actors' and partners' age moderated this pathway, revealing a positive link between partners' support and actors' intentions to persist for older couples. Further, when actors had a longer history of weight management, partners' support was positively related to actors' intentions to persist, however, when they reported a shorter history of prior attempts the association the was

nonsignificant. Partners' intentions to persist did not significantly predict actors' intentions to persist.

CHAPTER 4: DISCUSSION

The overarching purpose of this study was to explore the intrapersonal and interpersonal pathways linking compassionate and self-image goals to weight management goal pursuit. The current study utilized Pietromonaco and colleagues' (2013) model as a foundation for investigating the ways in which individuals regulate their own and partners' goals in the context of weight management. First, the current study explored the impact of compassionate and self-image goals, two common relationship orientations, that have been found to have consequences for the self and others (Crocker & Canevello, 2012a). Canevello and Crocker's theorizing situates compassionate and self-image goals early in the process for generating many psychological and relational experiences (Crocker & Canevello, 2018). In accordance with Pietromonaco and colleagues' model, interpersonal goals are linked to both affect (i.e., emotional responses to progress and setbacks) and dyadic behaviors (i.e., goal-relevant partner support). Further it pits these two mechanisms against each other in exploring consequences for health behaviors (i.e., intentions to persist): one affective and the other dyadic, both regulatory in nature.

Importantly, Pietromonaco's model stressed the importance of examining partner effects, suggesting that researchers specify the ways in which partners influence each other at various points in the model. The current study does so in several ways. First, it explored both intrapersonal and interpersonal pathways linking interpersonal goals to goal persistence. Second, it explored two sources of partner influence: partners' goal-relevant partner support and their own goal persistence. These sources represent both the active and passive ways partners influence each other on a daily basis. Further, this study

explored the ways in which characteristics of the partner moderate several hypothesized pathways. Results showed that partner characteristics (e.g., age, BMI) moderated both actor and partner effects, illuminating other ways in which measuring partner variables contributes to the study of weight management.

In the following sections, I discuss each path in the hypothesized model before discussing the broader importance, implications, and limitations of these findings.

Intrapersonal Pathways to Goal Persistence

Results of the current study generally did not support my hypotheses that interpersonal goals relate to emotional responses to progress and setbacks, which relate to intentions to persist. Contrary to Path A hypotheses, compassionate goals did not predict humble responses to progress nor did they predict human responses to setbacks. Contrary to my Path B hypotheses**,** self-image goals did not predict empowered responses to progress. Though, when people experienced less goal progress, self-image goals were negatively related to empowered responses to progress. Self-image goals did relate to ashamed responses to setbacks, however, this association was explained by several covariates, namely, setback amount, depressive symptoms, attachment anxiety, and relationship satisfaction.

This pattern of results is surprising, given the support for the hypothesized paths in other data. Analysis of hypotheses for Paths A and B using data from the *Goals and Adjustment to College Study* showed that compassionate goals consistently and directly predicted humble responses to progress and human responses to setbacks, whereas self-image goals consistently and directly predicted empowered responses to progress and ashamed responses to setbacks. Those findings replicated in both chronic analyses

exploring individual differences in interpersonal goals and analyses of weekly fluctuations exploring deviations from one's average levels of interpersonal goals.

Why, then, did findings from the current study differ? One distinction between the two studies was the specificity of measurement for interpersonal goals. In the *Goals and Adjustment to College Study* the goals were measured globally, referring to goals toward relationships with "others" more generally. Although previous research suggests some consistency in compassionate and self-image goals across relationships (e.g., friends, romantic partners, acquaintances; Li & Crocker, 2015), it is possible effects of the goals differ slightly across targets, particularly for a context that is sensitive to social comparison (Christensen & Jæger, 2018). In the current study, goals were partner-specific, such that people reported the extent to which they want to or try to be supportive of or manage the impressions of their partner in the context of their romantic relationship.

This is important because the hypothesized model was developed to explore interpersonal goals and emotional and support dynamics in a context *outside* of the relationship. That is, rather than measuring compassionate and self-image goals globally or in the same domain as the outcome, the current study explored associations between partner-specific goals and their consequences in the different, albeit highly interdependent, context of weight management. Thus, although it was important to measure partner-specific interpersonal goals to examine the interpersonal pathways discussed more fully later in the discussion, it may not have been ideal for the intrapersonal hypotheses.

Lack of evidence for direct associations between compassionate and self-image goals toward partners and emotional responses to progress and setbacks hints at the

possibility of mediation. Given their broad scope and links to interpersonal goals in previous research, feelings toward the goal more generally may be a strong contender. Compassionate goals have been linked to a cooperative mindset and feelings of ease and connection, whereas self-image goals have linked to a competitive mindset and feelings of unease and isolation (Canevello & Crocker, 2015; 2017; Crocker & Canevello, 2008). Feeling cooperative or competitive toward the goal more generally may influence how people appraise and subsequently respond to goal-relevant events. It may be the case that compassionate goals produce humble feelings in response to progress and human feelings in response to setbacks because compassionate goals foster a cooperative mindset during goal pursuit. When those with a cooperative mindset experience progress, they are likely to recognize the contributions of others and the tailwinds they may have encountered. When those with feelings of cooperative experience setbacks, they are likely to see failure as part of humanity and recognize that humans are imperfect. Thus, future research should explore whether compassionate goals foster a cooperative mindset that, in turn, fosters humble responses to progress and human responses to setbacks.

It may be the case that self-image goals produce feelings of empowerment in response to progress and shame in response to setbacks because self-image goals foster a competitive mindset toward the goal more generally. Competitiveness during goal pursuit may have negative downstream consequences, causing individuals to reduce their effort and even sabotage others (Huang, Lin, & Zhang, 2019). When those with competitive feelings toward their goal experience progress, they likely see the self at the center of their progress, resulting in boastfulness and feelings of empowerment. When those with a competitive mindset experience setbacks, they likely internalize their failure, seeing it as

a blemish to their competent image, thus, producing shame. Future research should examine whether self-image goals foster a competitive mindset that, in turn, predicts empowered responses to progress and ashamed responses to setbacks.

Results were mixed with respect to Path C hypotheses, which explored associations between emotional responses to progress and setbacks and intentions to persist. Contrary to hypotheses, humble responses to progress and human responses to setbacks were unrelated to intentions to persist. There was some evidence of moderation though. Age moderated both pathways suggesting that, for those who were younger, humble responses to progress and human responses to setbacks led to greater intentions to persist. For those who were older, human responses to setbacks (e.g., feeling *human, realistic, authentic*) led to lower intentions.

This is consistent with research suggesting that age and BMI influence health beliefs and diet-related intentions (Renner, Knoll, & Schwarzer, 2000). In general, individuals recognize the heightened risk that accompanies their increasing age and weight, and declining health. Younger adults, who tend to experience a heightened optimistic bias (Moutsiana et al., 2013), reported greater unrealistic optimism (i.e., lower perceived comparative risk) and lower intentions to change their diet compared to older adults (Renner et al., 2000). This is consistent with results of the current study showing that for younger adults, more realistic (vs. optimistic) responses to progress and setbacks (i.e., greater humble and human responses) were related to greater intentions to persist. Older adults reported greater functional optimism (i.e., greater perceived self-efficacy) and greater intentions to change their diet compared to younger adults (Renner et al., 2000). In the current study, older adults demonstrating more optimistic (vs. realistic)

responses to progress (i.e., lower human responses) experienced greater intentions to persist. Thus, age seems to significantly affect individuals' intentions to persist.

Further, when goal efforts were relatively new and when goal progress was greater, humble responses to progress were positively related to intentions to persist. These results may be evidence of an awareness of one's tailwinds: people who respond with humbleness to their progression at a new goal with relative ease or experiencing a great deal of progress are more likely to hold intentions to persist. This is consistent with work showing that feelings of gratitude, versus feelings of pride or joy, facilitates the contagion and subsequent pursuit of goals (Jia, Tong, & Lee, 2014).

Contrary to hypotheses, empowered responses to progress were positively related to intentions to persist, yet, this association was partially explained by progress amount. Thus, it appears that empowered responses to progress may be helpful, or at least not harmful, in the current study. Pride, one component of empowered responses, is shown to motivate people toward future achievements (Louro et al., 2007), which can lead to indulgent choices depending on cognitive and contextual factors (Wilcox, Kramer, & Sen, 2011). That is, pride promotes a sense of achievement (Fishbach & Dhar, 2005), which is linked to more indulgence (i.e., licensing). Pride also promotes a sense of self-awareness, which motivates goal-consistent behavior and less indulgence. Thus, it is possible that the link between empowered responses to progress and intentions to persist is moderated by individuals' sense of achievement or self-awareness.

In support of hypotheses, ashamed responses to setbacks were negatively related to intentions to persist, however, the association was explained by disordered eating symptoms and setback amount. The current study revealed moderate links between

disordered eating symptoms, ashamed responses to setbacks, setback amount, and intentions to persist (*pr*s = -.22 - .44). Thus, there was a large amount of shared variance detracting from the hypothesized association. Further, with fewer goal setbacks, ashamed responses were negatively related to intentions to persist. It may be the case that those who experience setbacks less frequently have stronger and more motivating shame responses and, therefore, more likely to abandon their goal. Thus, it appears that despite significant associations between these emotional responses and intentions to persist, disordered eating symptoms and the amount of progress and setbacks people experience play a direct and crucial role in their intentions to persist.

These findings were somewhat consistent with previous analyses. Path C hypotheses were also explored in the *Goals and Adjustment to College Study*, using future progress and setbacks as proxies for intentions to persist. Analyses showed that feeling humble in response to progress at Week 1 predicted decreased setbacks from Week 1 to 2, while feeling human in response to setbacks at Week 1 predicted increased progress from Week 1 to 2. Feeling empowered in response to progress at Week 1 marginally predicted increased progress from Week 1 to 2, whereas feeling ashamed in response to setbacks at Week 1 predicted increased setbacks and marginally predicted decreased progress from Week 1 to 2.

Why, then, did findings from the current study differ? Preliminary evidence from which most of the hypotheses were based was derived from research with a longitudinal design, measuring primary study variables weekly for 10 weeks. As such, hypotheses were tested chronically (by averaging measures across the 10 weeks) and using weekly fluctuations. In the current study, participants reported their goal-related experiences

retrospectively over the previous month. In addition to providing retrospective accounts of their progress and setbacks, the primary outcome was measured by asking individuals' intentions to persist and not abandon their goal. It is possible that the change in methodological design, from longitudinal to cross-sectional, and, thus, the timescale for measuring primary study variables, affected study results.

The consequences of the design change may be further amplified by the examination of a different goal type. Weight management behaviors like eating and physical activity are unique in that they require frequent effort; individuals must commit and recommit to their goal everyday (Glanz & Bishop, 2010). The health benefits of weight management goals tend to be unobservable and distal, thus: a) appraisals of progress and setbacks might differ from other goal types, and b) one month might be too small a window for assessing meaningful change, yet too large for assessing emotion dynamics. Thus, a longitudinal design with smaller windows of assessment may be useful in clarifying these associations.

Interpersonal Pathways to Goal Persistence

In support of Path D, partners' compassionate goals were associated with use of positive, goal-relevant partner support strategies in response to actors' weight management goals. Though, attachment avoidance and relationship satisfaction appear to explain why compassionate goals lead to partner support. Given previous research on compassionate goals, it's possible that this pathway is mediated by attachment and relationship quality. Past research has shown that fluctuations in compassionate goals predict fluctuations in attachment security (Crocker & Canevello, 2008). Similarly, previous research points to a directional link between compassionate goals and

relationship quality (Crocker, Canevello, & Lewis, 2017). Future research should test this possibility.

Contrary to my Path E hypothesis, partners' self-image goals were unrelated to goal-relevant partner support. Moderation analyses indicated that when actors or partners had a lower BMI, however, partners' self-image goals were associated with less partner support. It may be the case that when individuals have lower body mass, partners with the goal to maintain or defend a desired image perceive individuals as a threat or competition and, thus, behave in less supportive ways. A different process is likely occurring when partners are at a lower body mass. Here, when partners are at a lower BMI, partners high in self-image goals might have a lack of empathy for their partner's goal pursuit. That is, they may have difficulty taking their partner's perspective and, thus, provide less responsive support.

This pattern of findings is consistent with work from Crocker and Canevello (2008) on social support processes among college roommates. In their research, compassionate goals consistently predicted social support given, whereas, self-image goals were only marginally, negatively related to social support given. Further, they found an interaction effect, such that self-image goals undermined the positive effect of compassionate goals on social support. Another possibility is that self-image goals relate to use of negative goal-relevant support strategies in the context of weight management. Past research has demonstrated that people's motives for social influence alter their approaches to partner support. That is, those who are dissatisfied with their partner's weight out of concern for their health report use of more positive strategies whereas those dissatisfied with their partner's appearance are more likely to use negative strategies

(Burke & Segrin, 2014). Thus, it is plausible that in addition to less partner support when providers or recipients were at a lower BMI, self-image goals might lead to more critical or invalidating responses to their partner that are not captured by the measure of partner support.

I also examined the impact of partners' goal-relevant partner support on actors' intentions to persist. Partners' use of partner support strategies in response to actors' weight management goals did not impact actors' intentions to persist. There was, however, evidence of moderation for this pathway. First, actors' and partners' age moderated this pathway, which revealed a positive link between partners' support and actors' intentions to persist for older couples. This finding is consistent with theory suggesting that social relationships become more positive with age (Luong, Charles, & Fingerman, 2011). That is, older adults demonstrate a positivity bias by attending to positive and avoiding negative experiences (e.g., Charles, Mather, & Carstensen, 2003). They report more positive interactions with their romantic partners than objective coders observe, a bias that is not found for younger couples (Story et al., 2007). Older adults also engage in behaviors that facilitate positive relationships, like avoiding conflict more often than younger couples (Blanchard-Fields, 2007). Further, as they grow older, adults report deriving greater support from their close social ties (Schnittker, 2007). These positive experiences likely extend to their interactions in the context of weight management.

Age could also be confounded with weight gain, consequently, influencing the amount of support needed. Although age was not associated with BMI or goal type, age was positively associated with goal length, suggesting older individuals have been pursuing their goals longer. This interpretation is consistent with evidence from another

significant moderator: goal history. When individuals reported a longer history of prior weight management efforts, partners' support was positively related to individuals' intentions to persist. When individuals had fewer prior attempts, the association was nonsignificant. Thus, when goal pursuit was enduring, actors benefited from their partners support, however when it was a relatively new goal, support did not affect intentions. These findings may indicate that it takes time for partners to identify what support is most helpful for partners in the context of weight management. That is, support providers may begin by giving their partner support that fits their needs less well, but over time, learn what support strategies are most effective.

These findings also hint at a gap between partners' reported actions and actors' reported intentions, requiring more intermediate steps than the hypothesized model specified. Often times, that intermediate step is actors' perceptions of their partner's behavior. Indeed, other research demonstrates this bridge. In their study of responsiveness, Canevello and Crocker (2010) found that partners' responsiveness predicted actors' perceptions of partner's responsiveness, which in turn, predicted actors' relationship quality. This also replicates in romantic relationships in the context of a problem discussion (Collins & Feeney, 2000). Thus, it is possible that perceptions of partner's helpfulness, a global appraisal of support that taps into the perceived fit or appropriateness of support, mediates this pathway. Indeed, previous research by Overall and colleagues (2010) found partners' support predicts individuals' perceptions of partner helpfulness, which, in turn, predicts individuals' self-improvement over time. Thus, it is possible that actors' perceptions of partner helpfulness bridges the gap between partners' support and actors' intentions to persist.

The current study also tested the hypothesis that intentions to persist were contagious across partners (Path G). Results did not support this hypothesis, although the effect trended in the hypothesized direction. Nevertheless, descriptive statistics showed that nearly half of the sample reported eating 11+ meals together and exercising at least 1-2 times a week with their partner. This is consistent with past research showing concordance in romantic partners' health behaviors (Meyler et al., 2007). Despite the fact that partners' intentions to persist do not predict actors' intentions to persist above and beyond actors' preceding variables (i.e., intrapersonal pathways), it is possible that couples' concordance exists for other aspects of goal pursuit. Further, it is possible that the association between actors' and partners' intentions to persist is stronger among couples who are closer or more satisfied in their relationships. Future research should test the moderating role of these relational factors.

Implications for the Study of Close Relationships

The current study contributes to the growing literature on the link between chronic interpersonal goals and health (see Canevello & Crocker, 2011 for review). These relationship-related individual differences have an established link to important mental health outcomes, including anxiety, depression, and psychological distress (Canevello & Crocker, 2011; Crocker et al., 2010). Less is known about the links between interpersonal goals and physical health, though research has found compassionate goals to buffer neuroendocrine stress responses (Ableson et al., 2014). To my knowledge, this is the first empirical study to examine health behavior change processes using the egosystem-ecosystem theory of social motivation. While not all of the study hypotheses were supported, findings from primary and moderation analyses point to the possibility that

interpersonal goals have some consequences for the self and partner in the context of weight management.

This study attempted to clarify how compassionate goals function in a weight management context. Though inconsistent with previous work on compassionate goals and goal-related affect (Canevello & Crocker, 2015; 2017), findings extend this work by illuminating consequences of goal-related affect in the context of weight management. Moderation analyses provide support that, for some (e.g., younger participants), emotional responses theorized to be derived from the ecosystem (i.e., humble responses to progress, human responses to setbacks) contribute to intentions to persist in the context of weight management. While moderation analyses shed light on the benefits of humble responses to progress and human responses to setbacks for intentions to persist, future work is needed to clarify the current pattern of results and extend these findings to goal-relevant behavior.

Findings from this study also shed light on how self-image goals function in a weight management context. The current study suggests self-image goals produce goal-related affect that is self-directed in the context of weight management. Specifically, self-image goals were associated with greater ashamed responses to setbacks that, in turn, were negatively associated with intentions to persist. These findings are consistent with work linking self-image goals to other affective experiences that are self-focused (Canevello & Crocker, 2015). Given the context of weight management is particularly image-related, the egosystem may be more active here than in other goal contexts; influencing how people interact with others who have the same (or a similar) goal.

In addition to the hypothesized intrapersonal effects examined in the current study, interpersonal goals may also affect other intrapersonal aspects of weight management goal pursuit. Although those with compassionate and self-image goals likely pursue similar goals, the reasons why and, thus, how they frame those goals may differ. It is possible that interpersonal goals influence goal framing (e.g., getting stronger/healthier vs. improving my appearance). Compassionate goals were related to pursuing their goal "to feel more healthy", $\beta = .14$, $t(130.79) = 2.53$, $p = .01$ [95% CI = .03, .25], whereas self-image goals were not, $\beta = -.04$, $t(119.65) = -.77$, $p = .44$ [95% CI = -.15, .06]. This is important because goal framing has consequences for goal pursuit (Vansteenkiste et al., 2004) and might set those guided by different orientations up for success or failure from the very beginning.

How people appraise their goal relevant experiences might also differ by interpersonal goal. This is important because people are more likely to succeed when they appraise setbacks as opportunities to learn instead of signs of inadequacy (i.e., self-theories; Dweck, 2013). In the current study, compassionate goals were unrelated to perceptions of goal progress, $\beta = .17$, $t(132.59) = 1.63$, $p = .11$ [95% CI = -.03, .36]. Although counter to what one might initially expect, this finding suggests that those with compassionate goals are not wearing rose colored glasses, they see the goal pursuit process (their inputs and outputs) accurately. Those with self-image goals tend to perceive more goal setbacks, $\beta = .19$, $t(131.08) = 2.38$, $p = .02$ [95% CI = .03, .34]. Further, self-image goals were negatively related to intentions to persist, $\beta = -.20$, $t(126.28) = -2.33$, $p = .02$ [95% CI = -.36, -.03], suggesting that self-image goals also affect people's behavioral intentions. It may be the case that people with self-image goals

experience the goal process differently or that they struggle to keep focus on their goals because of their tendency to narrowly focus on the present. This is critical to explore further, given that concrete, local construals of goals and goal-related events tend to lead to self-control failure (Fujita, 2008).

Finally, this work builds on previous research showing that compassionate and self-image goals have consequences for the partner. In the current study, compassionate goals predict use of goal-relevant partner support, consisting of action facilitating and nurturant support strategies. This is consistent with previous research linking compassionate goals to partner support (Crocker & Canevello, 2008) and responsiveness (Canevello & Crocker, 2010). Individuals with compassionate goals may be more attuned to and show greater understanding for their partner's weight management efforts.

Self-image goals were unrelated to goal-relevant partner support; however, moderation analyses revealed some interesting boundaries of this association. Both actors' and partners' BMI moderated associations between partners' self-image goals and provision of partner support. When partners were at a lower BMI, their self-image goals were negatively related to their provision of partner support. This may be evidence of a lack of empathy for their partner, as they judge their partner's efforts more harshly because of their own successes and, thus, use fewer positive strategies. Further, when individuals had a lower BMI, their partners' self-image goals led to less support. Partners' self-image goals may lead to less support because they view what their partner's success says about them. This social comparative lens can result in jealousy or anger toward the partner and, thus, less positive strategy use.

More broadly, the current study adds to a growing body of literature on how partners influence individuals' weight management behaviors and goals (Huelsnitz et al., 2018). Both partners were currently pursuing weight management goals, demonstrating linkage that could be the result of partner selection or goal contagion. It is unlikely mere selection, as previous research has demonstrated an increase in partners' concordance for physical activity over time (Cobb et al., 2015). Thus, it is likely the case that partners are catching and subsequently pursuing the goals of those nearest to them (Aarts et al., 2004; Laurin, 2016), demonstrating evidence of goal contagion in this domain. Although the current study does not provide evidence of linkage between actors' and partners' intentions to persist, it is possible that partners transmit other qualities of the goal, including motives, attitudes, emotions, and behaviors, between one another.

A number of avenues for future research emerge if associations between individuals' and their partners' goal pursuit can be attributed to goal contagion. It is unclear whether partners' weight management goals arose independently or whether one partner's pursuits inspired the other. In addition to determining facets of goals that are contagious, future work might examine the origin of influence. Extant literature suggests people are more likely to take on other's goals when they perceive the other pursuing a goal with great effort (Dik & Aarts, 2007), feel connected to the actor (Loersch et al., 2008), hold less power in the relationship (Laurin et al., 2016), and when the goal is compatible and not in conflict with their preexisting goals (Radel et al., 2015). Future work should examine whether these conditions for goal contagion replicate in the context of weight management.

Beyond the unintentional effects partners may have on one another are those behaviors enacted with the intention to change the other. Initially, partners' support strategies did not affect individuals' intentions to persist. This may be consistent with studies of received support that find null or adverse outcomes when actual support is enacted (e.g., Barrera, 1986; Coyne & Bolger, 1990; Kaul & Lakey, 2003). Researchers posit that this paradox might be explained by the visibility of partners' support behaviors (e.g., Bolger, Zuckerman, & Kessler, 2000). In their study, support that went unnoticed, called *invisible support*, prompted greater reductions in distress than *visible support*. Building upon Bolger and colleagues earlier work, Maisel and Gable (2009) found that visible and invisible support were associated with positive outcomes when the partner was perceived as responsive.

Results may be consistent with this notion. It is possible that the nonsignificant main effect between partners' support and individuals' intentions to persist can be attributed to individuals' inability to detect their partner's support, which may indicate that support was invisible to the partner. It could also be the case that partner support does not affect this particular outcome (i.e., intentions to persist), instead affecting other aspects of goal pursuit. This hypothesis aligns with previous work demonstrating support provision to facilitate goal implementation among romantic couples pursuing the goal to become physically active (Berli, Bolger, Shrout, Stadler, & Scholz, 2018). That is, on days when support provision was high, partners were active for an additional 25 minutes. Joint engagement mediated this effect, suggesting that another type of partner support not captured in the current study.

The current study also illuminates an interesting boundary to support that is context dependent. Individuals' goal history moderated the effect of partners' support on individuals' intentions to persist. When individuals reported a longer history of weight management goal pursuit, their partners' support was positively related to the individual's intentions to persist; however, when they reported shorter histories, partner support and intentions to persist were unrelated. This moderator may provide indirect evidence of growing responsiveness. Early on, support may not be very responsive to recipients' needs, as both individuals learn to navigate a new goal. Over time, partners may learn what strategies are effective and, thus, begin implementing more responsive support. Research should explore whether support becomes more responsive as goal pursuit endures.

Implications for the Study of Weight Management

Researchers have identified a number of mechanisms through which close relationships affect health, that includes psychosocial pathways, biological pathways, and health and lifestyle pathways (Pietromonaco & Collins, 2017; Pietromonaco et al., 2013). While research has predominantly focused on the psychosocial and biological pathways linking close relationships to health, few studies have examined the behavioral pathways linking close relationships to health (Huelsnitz et al., 2018; Pietromonaco et al., 2013). Further, findings from a meta-analysis suggest that social relationships have a greater impact on mortality than some of the most well-documented behavioral risk factors (e.g., tobacco use and physical inactivity; Holt-Lunstad, Smith, & Layton, 2010). So notable are these findings that the authors urge public health researchers and officials to focus on fostering high quality relationships to reduce risk for mortality in addition to their current

efforts (Holt-Lunstad & Smith, 2012). Thus, interpersonal influences on health behavior have become ripe for exploration and intervention.

The current study builds on existing research by utilizing dyadic methodologies (Pietromonaco et al., 2013). Researchers have begun offering nuanced frameworks for incorporating dyads into traditionally intrapersonal theories of behavior change (Karney et al., 2010; Pietromonaco & Collins, 2017). For example, Howland and colleagues (2016) utilized a dyadic framework to investigate actors' and partners' attitudes, norms, and intentions for physical activity (i.e., the Theory of Planned Behavior). In the current study, partners completed parallel surveys, assessing characteristics of and responses toward their own and their partner's weight management goals. This afforded us the opportunity to examine how partners influence one another's goal pursuit but also to corroborate responses for important goal-related processes.

Findings from the current study demonstrate that collecting data from both partners is useful for the study of health behavior change. Moving forward, health researchers and practitioners should consider the interpersonal context in which weight management goals and behaviors occur. In particular, it would benefit researchers to assess characteristics of the partner, such as their social motives, BMI, and weight management goals and behaviors, as well as their level of awareness and involvement in the individual's goal pursuit. Clinicians should also be advised to involve the partner in weight management efforts. To do so, practitioners could focus on fostering communication about what individuals' need from their partner, friends, or family to be successful in their goal pursuit. They could even go as far as to offer training on positive

partner support strategies and how to approach support given their partner's history of weight management efforts.

The current project also explored affective processes as mechanisms for understanding the intrapersonal pathways to health goal striving—building on existing knowledge stemming from theories of self-regulation (Mann et al., 2013) and filling important gaps in our understanding of the affective mechanisms linking close relationships and health (Farrell et al., 2018). Findings from the current study speak to the possibility that emotions provide valuable information about goal progress and setbacks. People reported feeling humble and empowered in response to progress and human and ashamed in response to setbacks. According to theory, these emotional experiences should provide motivation for future goal-relevant action. Indeed, the current study provides some evidence that these emotional responses have consequences for goal intentions. Future work should build on this research by exploring their consequences for goal-relevant behavior.

Psychological and emotional factors are known barriers to goal attainment (Baumeister et al., 2007a). Therefore, emotional responses to setbacks could be an early warning sign of goal abandonment and, thus, a point of intervention for weight management programs. Health researchers and practitioners should heed this subtle information, which may fly beneath the radar of traditional health questionnaires assessing anxiety, depression, or disordered eating. Further, weight management interventions might involve attending to and supporting goal-related affect, in addition to providing standard behavioral weight loss treatment (i.e., support for dietary and exercise strategies). Indeed, researchers provide strong theoretical rationale for utilizing

Acceptance and Commitment Therapy for weight management efforts (Lillis & Kendra, 2014), which could address problematic emotions, like ashamed responses to setbacks, that tend to derail weight loss maintenance.

Limitations and Caveats

Interpretation of findings from the current study should take into account a number limitations and caveats. In the current study, weight management goals were defined as those that involve "engaging in health-promoting practices to increase, maintain, or decrease your current weight." In defining inclusion criteria as a goal involving weight exclusively, we may have failed to capture those attempting to reach a heathy body shape. Indeed, after failing the eligibility screener, many stated that although they did not have a desire to reach or maintain a certain weight, they did have a goal about their shape or general fitness. Despite using similar strategies (i.e., eating and physical activity) to meet their goal, the current study precluded those who framed their goal in terms beyond weight. Similar studies have used broader goal contexts, such as self-improvement (Overall et al., 2010), academic, or social goals (Canevello & Crocker, 2017), allowing for more inclusive, generalizable samples in which to test hypotheses.

Importantly, this study speaks specifically to relationships where both partner are pursuing a weight management goal. Thus, findings may not generalize to romantic couples where only one partner is pursuing a weight management goal. Mixed-weight couples (particularly those including an overweight woman and healthy weight man) experience greater conflict (Burke et al., 2012) and lower relationship satisfaction (Meltzer, McNulty, Novak, Butler, & Karney, 2011) compared to matched-weight couples. Though, partner support seems to buffer this conflict (Burke et al., 2012). The

current study provides some preliminary evidence that actors' and partners' BMI impact dyadic behaviors. Future work should explore the dyadic processes like goal contagion and partner support in couples where only one partner reported a weight management goal.

Providing further limits to generalizability, the current study reached a smaller sample size than was anticipated. Power analyses recommended a sample of at least 89 couples to detect small-medium actor and partner effects. This was a challenge as both partners were required to meet strict eligibility criteria. Recruitment efforts for the current study determined that approximately 30-40% of couple members willing to participate in the study were eligible, making the likelihood that both partners would meet criteria approximately 9%-16%. Nevertheless, many effects trended in the hypothesized direction despite being nonsignificant and, on a number of occasions, significant effects were detected.

While there were several notable strengths of the sample: participants ranged in age and represented varying BMI categories, relationship statuses, and living situations, the size of the sample contributed to a fairly homogenous dataset. Specifically, participants were primary White, college educated, and most reported a higher subjective social status. Although Americans at varying socioeconomic statuses share similar views on marriage (Trail & Karney, 2012), low-income Americans are less likely to marry and more likely to divorce than high-income Americans (Karney & Bradbury, 2005). Recent theorizing by Finkel and colleagues (2015) posits that, for low-income Americans, acute stressors encountered in daily life force people to prioritize lower-order needs (e.g., safety), rather than focusing on higher-order needs (e.g., esteem, self-actualization).

Thus, it is possible that lower-income Americans have less time to focus on regulation of their own and their partners' weight management goals. If so, setbacks may be more frequent, emotional responses more amplified, and partner support less available among low-income samples.

It is possible that low rates of eligibility described above, and the resulting homogenous sample, can be attributed to the prevalence and conceptualization of weight-related goals among people of color. For instance, overweight Black women are less susceptible to thin body ideals than White women (Chithambo & Huey, 2013) as evidenced by their lower drive for thinness, lower weight-based contingencies of self-worth, and higher appearance esteem than White women (Sabik, Cole, & Ward, 2010). Such factors may have influenced the rates and conceptualization of weight management goals among people of color. Thus, future research should examine the nuances of weight-related health goals within a more diverse sample.

Furthermore, participants in the current study were in generally happy, long relationships. Interestingly, relationship satisfaction related to a number of intrapersonal and interpersonal factors, including greater compassionate goals, empowered responses to progress, goal persistence, and social support and less ashamed responses and self-image goals. These associations allude to the possibility that appraisals of relationship quality have important implications for people's experiences in social and non-social contexts. Indeed, relationship quality consistently moderates associations between relationship status and health outcomes (Kiecolt-Glaser & Newton, 2001). Given the ceiling effect encountered for relationship satisfaction in the current study, it is possible that effects do not extend to unhappy couples. Distressed couples may suffer from poorer

emotional health and poor emotional health may contribute to greater relationship distress (Kiecolt-Glaser & Wilson, 2017). This extends to the current study, as the emotions experienced as a result of progress or setbacks may cause distress in people's everyday lives.

The current study was designed as a first test of a comprehensive theoretical model featuring both intra- and interpersonal pathways to goal persistence, and thus tested study hypotheses on a single occasion. Given the cross-sectional design of the present study, I cannot specify causality between study variables. Although findings from the current study are consistent with previous work, particularly for the interpersonal findings, experimental research is needed to more clearly establish directionality. It is possible that findings are more nuanced than the theorized model suggests, such that several processes are reciprocal. Though, other work sheds light on the directionality of some of the processes under investigation (Canevello & Crocker, 2017; Crocker & Canevello, 2008).

Because the current study was designed as an initial test of a theoretical model, it used more accessible survey methods to establish associations. Thus, the current study relies on retrospective self-reports for its primary predictors and self-reported intentions for goal persistence, the main outcome of interest. Because of this, it is possible that results may be biased by social desirability and self-evaluations. Though, controlling for individual differences and relationship factors had minimal impact on primary analyses. Despite these concerns, self-reports may be the most appropriate method for assessing intrapsychic experiences, like goals and emotions (Baumeister, Vohs, & Funder, 2007). Future studies should build on this work by incorporating more objective elements for

examining weight management, such as body fat scan, as well as observational methods to examine interpersonal dynamics as they unfold in real time.

Conclusions

Given the importance of weight management for health, the current study tested a novel model that integrates theory and constructs from relationship science, affective science, and health psychology to explore the impact of social relationships on weight management goal pursuit. Importantly, the present study offers insight into how compassionate and self-image goals contribute to own and romantic partner's regulation of weight management goals, providing a nuanced perspective on the highly interdependent context of weight management. Results supported several pathways to intentions to persist at weight management, providing health researchers and practitioners with promising points of intervention for producing meaningful change in a particularly complex goal context.

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APPENDIX A: ELIGIBILITY SCREENER

ELIGIBILITY SCREENER

This survey will assess your eligibility for the current study. It's important for you to answer the questions as honestly and accurately as possible.

What is your age? _____

What is your sex?

- ☐ Female
- ☐ Male
- ☐ Other (please specify):

What is your current relationship status?

- ☐ Single (i.e., no current sexual or romantic partners)
- ☐ I am in a sexual, but non-romantic relationship
- ☐ Casually dating (i.e., I am in a non-monogamous romantic relationship)
- ☐ Exclusively dating (i.e., I am in a monogamous romantic relationship)
- ☐ Engaged to be married
- ☐ Married/Civil Union/Domestic Partnership
- ☐ Other (please specify):

My current relationship is with someone:

- ☐ of the same sex.
- ☐ of the opposite sex.

How long have you been in your current relationship?

Years: _____ Months: _____

A ***weight management goal*** involves engaging in health-promoting practices to increase, maintain, or decrease your current weight.

Over the past month:

- ☐ I did not have a weight management goal, and I did not think about setting one.
- ☐ I did not have a weight management goal, but I thought about setting one.
- ☐ I had a weight management goal that I rarely pursued.
- ☐ I had a weight management goal that I sometimes pursued.
- ☐ I had a weight management goal that I pursued about half the time.
- ☐ I had a weight management goal that I pursued most of the time.
- ☐ I had a weight management goal that I always pursued.

My weight management goal was to _____ my current weight.

- ☐ increase
- ☐ maintain
- ☐ decrease

How tall are you? Please specify in feet and inches (e.g., 5 ft. 8 in.)
Feet: _____ Inches: _____

How much do you <u>currently</u> weigh (in lbs.)? If uncertain, please give your best estimate. _____

What is your <u>desired</u> weight (in lbs.)? _____

Has a health professional ever diagnosed you with an eating disorder (e.g., bulimia, anorexia, binge-eating disorder, etc.)?

- ☐ Yes
- ☐ No

APPENDIX B: SURVEY MATERIALS

This first set of questions ask about your health goals and behaviors. Please try to answer these next questions as honestly as possible.

Thinking about your desire to manage your current weight:

1) **What was your <u>main</u> goal in the past month?**
2) **How did you try to meet that goal?**

Please provide a detailed description of your goal and how you tried to meet it on the index card provided by the researcher. You may hand it to the researcher when you are finished.

	YEARS:	MONTHS:
How long have you had this goal? (Ex: 1.5 years = YEARS: <u>1</u> MONTHS: <u>6</u>)	_____	_____

	Not at All			A Moderate Amount			A Great Deal
How much have you attempted to achieve similar weight management goals **<u>in the past</u>**?	1	2	3	4	5	6	7

Personally, I am pursuing this weight management goal:	Not at all true for me					Very true for me
To prevent health problems	0	1	2	3	4	5
To feel more healthy	0	1	2	3	4	5
Because my doctor/others advised me to	0	1	2	3	4	5
To improve my appearance	0	1	2	3	4	5

Over the <u>NEXT MONTH</u>, how likely are you to:	Not at all likely			Somewhat likely			Very likely
1. stick with your goal to manage your weight?	1	2	3	4	5	6	7
2. abandon your goal to manage your weight?	1	2	3	4	5	6	7
3. get distracted by new ideas and projects while pursuing your goal to manage your weight?	1	2	3	4	5	6	7
4. be discouraged by setbacks while pursuing your goal to manage your weight?	1	2	3	4	5	6	7
5. lose interest in your goal to manage your weight?	1	2	3	4	5	6	7
6. work hard toward your goal to manage your weight?	1	2	3	4	5	6	7

7.	choose to pursue a different goal instead of your current goal to manage your weight?	1	2	3	4	5	6	7
8.	have difficulty maintaining focus on your goal to manage your weight?	1	2	3	4	5	6	7
9.	make/maintain progress toward your goal to manage your weight?	1	2	3	4	5	6	7
10.	be diligent in pursuing your goal to manage your weight?	1	2	3	4	5	6	7

Over the PAST MONTH:	**Not at all**	**Slightly**	**Moderately**	**Very**	**Extremely**
How important was your goal?	1	2	3	4	5
How difficult was your goal?	1	2	3	4	5
How clear was your goal?	1	2	3	4	5
How confident were you that you could achieve your goal?	1	2	3	4	5

	Tried Not at All			**Tried A Moderate Amount**			**Tried a great deal**
Over the **past month**, how hard did you try to achieve your goal?	1	2	3	4	5	6	7

	Not very successful			**Somewhat successful**			**Very successful**
Over the **past month**, how successful have you been at sticking with this goal?	1	2	3	4	5	6	7

INSTRUCTIONS: The following statements describe strategies and behaviors that individuals may engage in when they are trying to manage their weight. Although people have intentions to change their eating or exercise behaviors, sometimes they don't. This is extremely common and happens for a variety of reasons.

Please select the numbers that best describes how much you **intended to do** each of the following during the **past month**.		**Not at All**	**A little**	**Somewhat**	**A lot**	**Very much**
1.	keep a record of the type and amount of food I eat.	0	1	2	3	4
2.	set exercise goals for myself.	0	1	2	3	4
3.	keep low-calorie foods (e.g., fruit, raw vegetables, unbuttered popcorn) accessible for a healthy snack.	0	1	2	3	4
4.	make up for missed exercise on one day by exercising longer another day.	0	1	2	3	4
5.	have several servings of fruits and/or vegetables each day.	0	1	2	3	4
6.	keep a record of the calories and fat in the foods I eat.	0	1	2	3	4
7.	keep high calorie, high fat foods (e.g., chips, cookies, cakes) out of sight so they would not tempt me.	0	1	2	3	4

8.	have a plan for getting my exercise in if the weather is bad and I can't exercise outside.	0	1	2	3	4
9.	set a daily calorie goal for myself.	0	1	2	3	4

Over the <u>PAST MONTH</u>, to what extent did your weight management goal make you feel:	**Not at All**	**A little**	**Somewhat**	**A lot**	**Very much**
1. Competitive	1	2	3	4	5
2. Clear	1	2	3	4	5
3. Loving	1	2	3	4	5
4. Confused	1	2	3	4	5
5. Peaceful	1	2	3	4	5
6. Ambivalent/Conflicted	1	2	3	4	5
7. Cooperative	1	2	3	4	5
8. Fearful	1	2	3	4	5

	None at all	**A little**	**A moderate amount**	**A lot**	**A great deal**
In the **<u>past month</u>**, how much did you experience ***setbacks*** in pursuing your weight management goal?	1	2	3	4	5

Please describe your ***setback(s)*** using the space provided below:

To what extent did ***setbacks*** in pursuing your weight management goal make you feel:	**Not at All**	**A little**	**Somewhat**	**A lot**	**Very much**
1. Inferior	1	2	3	4	5
2. Authentic	1	2	3	4	5
3. Weak	1	2	3	4	5
4. Wanting to learn	1	2	3	4	5
5. Determined	1	2	3	4	5
6. Human	1	2	3	4	5
7. Powerless	1	2	3	4	5
8. Ashamed	1	2	3	4	5
9. Realistic	1	2	3	4	5
10. Victimized	1	2	3	4	5
11. Responsible	1	2	3	4	5
12. Out of control	1	2	3	4	5
13. Critical of yourself	1	2	3	4	5

	None at all	**A little**	**A moderate amount**	**A lot**	**A great deal**
In the **<u>past month</u>**, how much ***progress*** did you make in pursuing your weight management goal?	1	2	3	4	5

Please describe your ***progress*** using the space provided below:

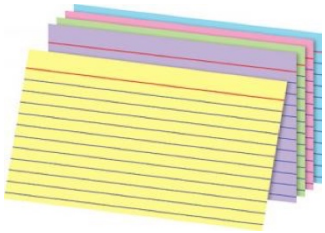
To what extent did your ***progress*** in pursuing your weight management goal make you feel:	Not at All	A little	Somewhat	A lot	Very much
1. Proud of myself	1	2	3	4	5
2. Superior	1	2	3	4	5
3. Admirable	1	2	3	4	5
4. Compassionate	1	2	3	4	5
5. Curious	1	2	3	4	5
6. Centered	1	2	3	4	5
7. Powerful	1	2	3	4	5
8. Strong	1	2	3	4	5
9. Fallible	1	2	3	4	5
10. Joyful	1	2	3	4	5
11. In control	1	2	3	4	5
12. Humble	1	2	3	4	5
13. Content	1	2	3	4	5
14. Grateful	1	2	3	4	5
15. Indestructible	1	2	3	4	5

The next set of questions ask about ***your partner's*** reactions to ***your*** health goals and behaviors. Please try to answer these next questions as honestly as possible.

Over the <u>PAST MONTH</u>:	Not at all	Slightly	Moderately	Very	Extremely
How much did you and your partner discuss your goal?	1	2	3	4	5
How difficult did your partner think your goal was for you to achieve?	1	2	3	4	5
How much did your partner value your goal?	1	2	3	4	5
How confident was your partner that you could achieve your goal?	1	2	3	4	5
How helpful was your partner with your goal?	1	2	3	4	5
How aware was your partner of your goal?	1	2	3	4	5
How clear was your goal to your partner?	1	2	3	4	5

In the <u>PAST MONTH</u>, my partner:	Not at all				Very frequently
1. offered to work together with me to achieve my goal.	1	2	3	4	5
2. behaved warmly and affectionately toward me when discussing my goal.	1	2	3	4	5

3.	complimented and made me feel good about other aspects of myself.	1	2	3	4	5
4.	criticised the progress I was making in pursuing my goal.	1	2	3	4	5
5.	helped me make a plan regarding how I could meet my goal.	1	2	3	4	5
6.	told me that if I had done things differently I wouldn't need to pursue this goal.	1	2	3	4	5
7.	made me feel that I had the ability to achieve my goal.	1	2	3	4	5
8.	offered me good, practical advice on how to achieve my goal.	1	2	3	4	5
9.	showed me that they love and accept me as I am.	1	2	3	4	5
10.	told me that it was my fault that I needed to pursue this goal.	1	2	3	4	5
11.	was rude and abrupt in their comments about my goal.	1	2	3	4	5
12.	helped me think of ways I could pursue my goal.	1	2	3	4	5



The next set of questions ask about ***your*** reactions *to* ***your partner's*** health goals and behaviors.

Before beginning this section, please read the description of your partner's goal from his/her index card and take a few moments to think about his/her goal.

Please try to answer these next questions as honestly as possible.

	Not very likely						Very likely
Over the **next month**, how likely is ***your partner*** to stick with his/her goal?	1	2	3	4	5	6	7

Over the PAST MONTH:	Not at all	Slightly	Moderately	Very	Extremely
How aware were you of your partner's goal?	1	2	3	4	5
How difficult did you think your partner's goal was for him/her to achieve?	1	2	3	4	5
How helpful were you with your partner's goal?	1	2	3	4	5
How clear was your partner's goal to you?	1	2	3	4	5
How much did you and your partner discuss his/her goal?	1	2	3	4	5
How much did you value your partner's goal?	1	2	3	4	5
How confident were you that your partner could achieve his/her goal?	1	2	3	4	5

	Tried Not at All						Tried a great deal
Over the **past month**, how hard did ***your partner*** try to achieve his/her goal?	1	2	3	4	5	6	7

	Not very successful			Somewhat successful			Very successful
Over the **past month**, how successful was ***your partner*** at sticking with his/her goal?	1	2	3	4	5	6	7

In the PAST MONTH:		Not at all				Very frequently
1.	I helped my partner think of ways they could pursue their goal.	1	2	3	4	5
2.	I behaved warmly and affectionately toward my partner when discussing their goal.	1	2	3	4	5
3.	I complimented and made my partner feel good about other aspects of him/herself.	1	2	3	4	5
4.	I was rude and abrupt in my comments about my partner's goal.	1	2	3	4	5
5.	I offered my partner good, practical advice on how to achieve their goal.	1	2	3	4	5
6.	I told my partner that if they had done things differently they wouldn't need to pursue this goal.	1	2	3	4	5
7.	I offered to work together with my partner to achieve their goal.	1	2	3	4	5
8.	I made my partner feel that they had the ability to achieve their goal.	1	2	3	4	5
9.	I criticised the progress my partner was making in pursuing their goal.	1	2	3	4	5
10.	I told my partner that it was their fault that they needed to pursue this goal.	1	2	3	4	5
11.	I showed my partner that I love and accept them as they are.	1	2	3	4	5
12.	I helped my partner make a plan regarding how they could meet their goal.	1	2	3	4	5

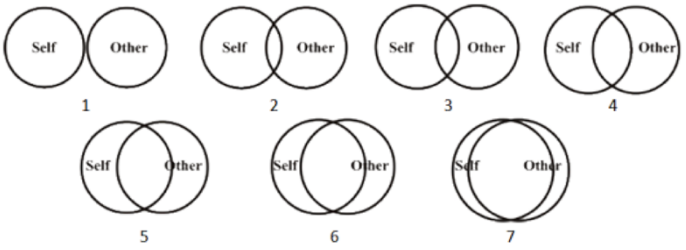
The next set of questions ask about your relationship with your romantic partner ***in general***. Please try to answer these next questions as honestly as possible.

In my relationship with my partner, I want / try to…		Not at all	A little	Somewhat	A lot	Extremely
1.	Have compassion for my partner's mistakes and weaknesses.	1	2	3	4	5
2.	Avoid being blamed or criticized.	1	2	3	4	5
3.	Be supportive of my partner.	1	2	3	4	5
4.	Convince my partner that I am right.	1	2	3	4	5
5.	Avoid saying things to my partner that I don't mean.	1	2	3	4	5
6.	Make a positive difference in my partner's life.	1	2	3	4	5
7.	Avoid the possibility of being wrong.	1	2	3	4	5
8.	Get my partner to respect or admire me.	1	2	3	4	5
9.	Avoid showing my weaknesses.	1	2	3	4	5

10.	Be constructive in my comments to my partner.	1	2	3	4	5
11.	Avoid being selfish or self-centered.	1	2	3	4	5
12.	Avoid doing anything that would be harmful to my partner.	1	2	3	4	5
13.	Get my partner to do things my way.	1	2	3	4	5
14.	Demonstrate my intelligence.	1	2	3	4	5
15.	Avoid neglecting my relationship with my partner.	1	2	3	4	5
16.	Get my partner to acknowledge my positive qualities.	1	2	3	4	5

INSTRUCTIONS: Please indicate what your current partner/relationship is like.		**Not at all**						**Extremely**
1.	How satisfied are you with your relationship?	1	2	3	4	5	6	7
2.	How committed are you to your relationship?	1	2	3	4	5	6	7
3.	How devoted are you to your relationship?	1	2	3	4	5	6	7
4.	How content are you with your relationship?	1	2	3	4	5	6	7
5.	How happy are you with your relationship?	1	2	3	4	5	6	7
6.	How much do you trust your partner?	1	2	3	4	5	6	7
7.	How dedicated are you to your relationship?	1	2	3	4	5	6	7

INSTRUCTIONS: Please select the picture that best describes your relationship with your romantic partner.



INSTRUCTIONS: The following statements concern how you feel in romantic relationships. We are interested in how you *generally* experience relationships, not just in what is happening in a current relationship. Respond to each statement by indicating how much you agree or disagree with it.

		Strongly Disagree	**Disagree**	**Slightly Disagree**	**Neutral**	**Slightly Agree**	**Agree**	**Strongly Agree**
1.	It helps to turn to my romantic partner in times of need.	1	2	3	4	5	6	7
2.	I need a lot of reassurance that I am loved by my partner.	1	2	3	4	5	6	7
3.	I want to get close to my partner, but I keep pulling back.	1	2	3	4	5	6	7

4.	I find that my partner(s) don't want to get as close as I would like.	1	2	3	4	5	6	7
5.	I turn to my partner for many things, including comfort and reassurance.	1	2	3	4	5	6	7
6.	My desire to be very close sometimes scares people away.	1	2	3	4	5	6	7
7.	I try to avoid getting too close to my partner.	1	2	3	4	5	6	7
8.	I do not often worry about being abandoned.	1	2	3	4	5	6	7
9.	I usually discuss my problems and concerns with my partner.	1	2	3	4	5	6	7
10.	I get frustrated if romantic partners are not available when I need them.	1	2	3	4	5	6	7
11.	I am nervous when partners get too close to me.	1	2	3	4	5	6	7
12.	I worry that romantic partners won't care about me as much as I care about them.	1	2	3	4	5	6	7

The next set of questions ask about your psychological health and well-being. Everyone experiences challenges at some point, so please answer honestly.

INSTRUCTIONS: Below is a list of statements dealing with your general feelings about yourself. Please indicate how strongly you agree or disagree with each statement.		**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**
1.	All in all, I am inclined to feel that I am a failure.	0	1	2	3
2.	I take a positive attitude toward myself.	0	1	2	3
3.	On the whole, I am satisfied with myself.	0	1	2	3
4.	At times I think I am no good at all.	0	1	2	3
5.	I feel that I have a number of good qualities.	0	1	2	3

INSTRUCTIONS: Below is a list of some of the ways you may have felt or behaved. Please indicate how often you have felt this way during the **PAST WEEK**.		**Rarely or none of the time** (less than 1 day)	**Some or a little of the time** (1-2 days)	**Occasionally or a moderate amount time** (3-4 days)	**Most or all of the time** (5-7 days)
1.	I was bothered by things that don't usually bother me	☐	☐	☐	☐
2.	I had trouble keeping my mind of what I was doing	☐	☐	☐	☐
3.	I felt depressed	☐	☐	☐	☐
4.	I felt that everything I did was an effort	☐	☐	☐	☐
5.	I felt hopeful about the future	☐	☐	☐	☐
6.	I felt fearful	☐	☐	☐	☐
7.	My sleep was restless	☐	☐	☐	☐
8.	I was happy	☐	☐	☐	☐
9.	I felt lonely	☐	☐	☐	☐
10.	I could not "get going"	☐	☐	☐	☐

On how many of the past 7 DAYS….		**0 days**	**1-2 days**	**3-5 days**	**6-7 days**
1.	Have you been deliberately trying to limit the amount of food you eat to influence your weight or shape (whether or not you have succeeded)?	☐	☐	☐	☐
2.	Have you gone for long periods of time (e.g., 8 or more waking hours) without eating anything at all in order to influence your weight or shape?	☐	☐	☐	☐
3.	Has thinking about food, eating, or calories made it very difficult to concentrate on things you are interested in (such as working, following a conversation, or reading)?	☐	☐	☐	☐
4.	Has thinking about your weight or shape made it very difficult to concentrate on things you are interested in (such as working, following a conversation, or reading)?	☐	☐	☐	☐
5.	Have you had a definite fear that you might gain weight?	☐	☐	☐	☐
6.	Have you had a strong desire to lose weight?	☐	☐	☐	☐
7.	Have you tried to control your weight or shape by making yourself sick (vomit) or taking laxatives?	☐	☐	☐	☐
8.	Have you exercised in a driven or compulsive way as a means of controlling your weight, shape or body fat, or to burn off calories?	☐	☐	☐	☐
9.	Have you had a sense of having lost control your eating (at the time that you were eating)?	☐	☐	☐	☐
10.	On how many of these days (*i.e., days on which you had a sense of having lost control over your eating*) did you eat what other people would regard as an unusually large amount of food in one go?	☐	☐	☐	☐

Over the past 7 DAYS….		**Not at all** 0	**Slightly** 1	**Moderately** 2	**Markedly** 3
11.	Has your weight or shape influenced how you think about (judge) yourself as a person?	☐	☐	☐	☐
12.	How dissatisfied have you been with your weight or shape?	☐	☐	☐	☐

INSTRUCTIONS: Listed below are a number of statements concerning personal attitudes and traits. For each statement, select the response that best reflects your feelings. It's best to go with your first judgment and not spend too long mulling over any one question.		**Yes**	**No**
1.	It is sometimes hard for me to go on with my work if I am not encouraged.	☐	☐
2.	I sometimes feel resentful when I don't get my way.	☐	☐
3.	On a few occasions, I have given something up because I thought too little of my ability.	☐	☐
4.	There have been times when I felt like rebelling against people in authority even though I knew they were right.	☐	☐
5.	No matter who I'm talking to, I'm always a good listener.	☐	☐
6.	There have been occasions when I have taken advantage of someone.	☐	☐
7.	I'm always willing to admit it when I make a mistake.	☐	☐
8.	I sometimes try to get even rather than forgive and forget.	☐	☐
9.	I am always courteous, even to people who are disagreeable.	☐	☐

10.	I have never been irked when people express ideas very different from my own.	☐	☐
11.	There have been times when I was quite jealous of the good fortune of others.	☐	☐
12.	I am sometimes irritated by people who ask favors of me.	☐	☐
13.	I have never deliberately said something that hurt someone's feelings.	☐	☐

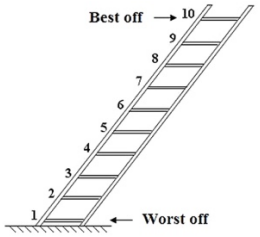
Your answers to the following items will help us interpret the results of the survey.

What do you consider your primary race/origin?

- ☐ **White** (e.g., Irish, German, Italian, Lebanese, Arab, Moroccan, etc.)
- ☐ **Hispanic, Latino/a, or Spanish Origin** (e.g., Mexican or Mexican American, Puerto Rican, Cuban Dominican, etc.)
- ☐ **Black or African American** (e.g., African American, Kenyan, Nigerian, Haitian, etc.)
- ☐ **American Indian or Alaska Native** (e.g., Navajo, Blackfeet, Inupiat, Central or South American Indian groups, etc.)
- ☐ **Asian** (e.g., Chinese, Filipino, Korean, Japanese, Vietnamese, etc.)
- ☐ **Native Hawaiian or Other Pacific Islander** (e.g., Native Hawaiian, Guamanian, Samoan, etc.)
- ☐ **Biracial or Multiracial**
- ☐ **Other** (*Please Specify*): _____
- ☐ I would rather not report this

Where would you place yourself on this ladder?
Please indicate a number, 1-10, where you think you stand at this time in your life, relative to other people in the United States.

1	2	3	4	5
☐	☐	☐	☐	☐
6	7	8	9	10
☐	☐	☐	☐	☐



What is the highest level of education you have completed?

- ☐ 11th grade or less (not high school graduate)
- ☐ High school graduate or G.E.D.
- ☐ Vocational or technical school after high school
- ☐ Some college, including 2 year degrees
- ☐ Bachelor's Degree
- ☐ Master's Degree
- ☐ Doctoral Degree (Ph.D., M.D., J.D., etc.)
- ☐ I would rather not report this.

Is your relationship with your partner long distance?	☐ **Yes**	☐ **No**

Are you and your partner currently living together?	☐ **Yes**	☐ **No**
IF YES:	**YEARS:**	**MONTHS:**
How long have you lived with your partner? (Ex: 1.5 years = YEARS: 1 MONTHS: 6)	_____	_____

How much time do you spend awake **with your partner** in an average week?

- ☐ less than five hours/week
- ☐ 5 -10 hours/week
- ☐ 11-15 hours/week
- ☐ 16-20 hours/week
- ☐ 20+ hours/week

How frequently do you eat **with your partner** in an average week?

- ☐ Less than 5 times per week
- ☐ 5-10 meals per week
- ☐ 11-15 meals per week
- ☐ 16+ meals per week

How frequently do you exercise in an average week?

- ☐ no times per week
- ☐ 1-2 times per week
- ☐ 3-4 times per week
- ☐ 5-6 times per week
- ☐ 7+ times per week

How frequently do you exercise **with your partner** in an average week?

- ☐ no times per week
- ☐ 1-2 times per week
- ☐ 3-4 times per week
- ☐ 5-6 times per week
- ☐ 7+ times per week

	Poor	**Fair**	**Good**	**Very good**	**Excellent**
In general, how would you rate your health?	☐	☐	☐	☐	☐

Please provide any additional comments or feedback you would like to share with our research team in the space provided below.